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ABSTRACT

This handbook is one of four handbooks developed for preservice and inservice counselor preparation and professional development. It was developed as a practical guide for practicing professionals and as a textbook or supplementary material for use in courses or workshops on consultation. It consists of six chapters. "Introduction to Consultation: An Intervention for Advocacy and Outreach" (DeWayne Kurpius and Joyce Lewis) defines advocacy and outreach, looks at the role of the consultant as advocate, and considers issues of consultation. "Empowerment through Advocacy" (Duane Brown) defines advocacy, lists the qualities of an advocate, considers skills and strategies of advocacy, describes the process of advocacy, and discusses ethics and advocacy and some problems in advocacy. "Consultative Advocacy Differentiated from Legal Advocacy" (Theodore Remley, Jr.) looks at attorneys as advocates and at consultants as advocates and then goes on to consider appropriate advocacy roles for consultants. "Consultation as Advocacy and Outreach in Community Mental Health Settings: Theory to Practice" (Gordon Gibson) examines the development of theory in consultation and at consultation interventions as advocacy and outreach. Case applications are provided for consultation as advocacy and as outreach. "Advocacy and Outreach: Applications to College/University Counseling Centers" (David Drum and Luis Valdes) looks at levels of need and presents an outreach model. "Advocacy and Outreach Through Consultation: Applications to Educational Settings" (Clarence Johnson and Sharon Johnson) discusses the role of the counselor as student advocate in a guidance program and presents 12 essential program elements of a results-based guidance program. Chapters include references. (NB)

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ASSOCIATION FOR COUNSELOR
EDUCATION AND SUPERVISION

**Handbook
of
Consultation: An Intervention
For Advocacy and Outreach**

Handbook of Consultation: An Intervention For Advocacy and Outreach

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Foreword

The Association for Counselor Education and Supervision is proud to add two handbooks to a growing series of practical publications offered for preservice and inservice counselor preparation and professional development. Two earlier publications, *Handbook of Counseling Supervision* and *Handbook of Administrative Supervision*, published in 1987 have been received with great enthusiasm and have outsold all expectations to date. These new handbooks, *Handbook of Consultation with Individuals and Small Groups* and *Handbook of Consultation: An Intervention for Advocacy and Outreach* are offered for your consumption and use in emphasizing the growing consultant role many practitioners are exercising.

It wasn't too many years back when field practicum was an exception to the rule and internships were unheard of, perhaps this is where consultation preparation is today. A small but growing number of counselor preparation programs have introduced coursework that emphasizes this important role. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) includes consultation as one of its required competencies. To date 49 counselor education programs throughout the country are CACREP approved. A growing body of research and literature is accumulating to support this ever expanding role of the counselor as can be seen by the list of references in this handbook.

As counselor educators, supervisors, and practicing counselors we find ourselves serving as consultants to a multifaceted clientele including, but not limited to, educational institutions, business and industry, human services agencies, legislative bodies, government agencies, allied professional associations, students, families, and many other individuals and groups. We also, in a peer relationship, serve as consultants to each other. Through some very painful lessons, for example, substance abuse, teen pregnancy, AIDS, teen suicide, structural unemployment, and human rights infringements, the public has at last discovered the need for the services available for

competent counselors. And, as we are called upon more frequently to testify, justify, and defend, we need to polish our consultation skills.

These handbooks will be useful as supplemental texts for courses and workshops in consultation and as helpful guides for practicing professionals. A very special note of gratitude is directed toward the better than 100 members of the ACES Consultation Network for fostering this important role of the counselor. Under the leadership of co-chairs Duane Brown and Jan Gill-Wigal this network has conducted research and promoted the need for counselors to be prepared as consultants. A special thanks is offered to Duane Brown, DeWayne Kurpius, and Joseph Morris, authors of the *Handbook of Consultation with Individuals and Groups*; and again to Duane and DeWayne for editing, *Handbook of Consultation: An Intervention for Advocacy and Outreach*. The contributors to this second handbook are also commended for their excellent contributions. ACES is fortunate to have these dedicated professionals who have given of their time and talents to bring us these very useful products. The ACES Media Committee members who reviewed the manuscripts in a very timely fashion are also recognized for their helpful feedback.

Joseph C. Rotter, 1987-1988 President
Association for Counselor Education and Supervision

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Chapter One

Introduction To Consultation: An Intervention for Advocacy and Outreach

DeWayne J. Kurpius and Joyce E. Lewis

Professionals functioning as consultants because of their unique and multiple roles as collaborators, mediators, facilitators, and liaisons, are in an excellent position to act as advocates and to facilitate outreach services. Frequently, the consultant may have insight into a need for advocacy that may be hidden from those closest to the problem or ignored by them. When following the goals of outreach and advocacy, they work toward altering situations which disenfranchise or dehumanize persons with whom they come in contact or serve as target populations.

Advocacy defined

What is advocacy? There can be many definitions in addition to that of Webster's dictionary, which defines an advocate as "one that pleads the cause of another" or "comes to the aid of another." Consideration of the roles of the consultant and the process of consultation will allow for other definitions as well. Advocacy may be better defined for consultants in terms of the actions involved and the roles required. For example, advocacy may be defined as a process for protecting the rights of those who are unable to help themselves, and to seek due process, aid, and treatment for those persons. In the case of consultation, the rights of clients or target populations will be considered. A consultant may see that the plan a consultee agency proposes may be potentially harmful to those it is pledged to serve,

e.g. a community mental health agency may decide to serve only those persons with insurance or cash to pay for services. A school system may decide to "mainstream" handicapped children before the system has the resources to provide appropriate services to those children.

Outreach defined

It is through outreach that advocacy may occur. Outreach is defined as extending or making known available services to target populations. Going out into a target area to establish branch services of an established human service agency or other system will take professionals out of their comfortable offices and into the real world where the needs of target populations may become more apparent. Outreach services should locate and serve populations where they exist, such as college students on the campus and residence halls, socioeconomically disadvantaged persons, many minority group members, the elderly at home, and deinstitutionalized chronic mentally ill persons on the streets. Outreach involves utilizing media and communication systems to make known available services to the population. Frequently, outreach services require diversification and non-traditional methods in order to locate populations in need, and to advocate and deliver services to them. Advocates may act as a resource linkage to other service networks. Without appropriate outreach programs, as illustrated in the Drum and Valdes and Gibson chapters, we lack knowledge and understanding of the needs of those persons we are pledged to serve, whether as counselors, consultants, or advocates.

The role of the consultant as advocate

The consultant, in the advocate modality, may function in many different ways. They may act as process consultants to help persons or groups to work together, or to promote self-advocacy. In the case of the handicapped children mentioned above, the consultant may facilitate group discussions as negotiations between parents and school personnel, aimed at altering a decision or providing a better climate for such decisions.

Consultants may act as "organizers" in which they identify target groups, find the resources needed for advocacy, and facilitate the advocacy effort. Consultants may also act as liaisons between and within groups or individuals in order to aid communication and exchange of information and resources. In so doing, they may alter the structure of systems in such a way that change occurs which will aid the population in need. As the Brown chapter points out, advocacy may involve "empowerment" - correcting the power balance and aiding those who feel powerless or who have limited power or influence.

The Drum and Valdes chapter states that advocates "seek change and prevention and remedy for others from others" to advocate a

specific change". Advocacy can be preventive as well as remedial, when consultants anticipate difficulties and advocate for change within a system before those difficulties actually occur. The "seven levels of need" model that Drum and Valdes use in a university counseling center is illustrative of both approaches.

The process role of advocacy is not without risk. As Brown's chapter points out, advocacy is not for the timid. It requires sensitivity to the needs and rights of others, and may frequently require strategies which alter the power relationships between communities, systems, and organizations; and the people within them and the clients served by these organizations. It will certainly require changing from a neutral collaborative/facilitative role to a more activist/mediator stance in most situations; and frequently, consultants may be forced to reconsider their loyalties to a particular group or system. They may also be forced to make judgments, choices, and decisions which may cause cost or inconvenience to some persons (including the advocate) in the course of improving the quality of life for others. Advocacy may require consultants to develop partnerships and/or affiliations with other persons or groups of persons seeking aid for themselves or others. Consultants will need to clarify their own values and loyalties, particularly if the advocacy role requires affiliating with persons other than the consultee or consultee agency who may be paying the consultant's fees. As Brown mentions, ethical standards for advocacy are not delineated. Accepting payment for employment is considered agreement with the consultee's policies, terminating employment may circumvent the problems of conflicts of interest, values, and loyalties. Consultants must decide if their first responsibility is to the "employer", or if it is to promote growth and well-being and to protect the welfare and rights of clients and target populations. If an individual acts as consultant as part of their duties of employment (i.e., an "inside" consultant, such as a school psychologist), they may encounter many such conflicts of loyalty and interest.

Issues

The special issues of school consultation have been frequently discussed in the literature. Children who may be handicapped physically, emotionally or intellectually are a target group who have traditionally been outside the norms of public education systems. In recent years, there has been increased focus on the rights and welfare of these and all other children. Of particular concern is the penchant of school systems to "label" children in order to receive state and federal aid. Assigning children to a diagnostic category which sometimes bears little relationship to the actual condition of the child offers one example of the need for advocacy in school systems. School counselors, school psychologists, and teachers may act as advocates to protect rights and welfare of students and parents and to improve the social and intellectual competence of the children in their

care. Consultants may facilitate the abilities of parents as advocates on behalf of their children.

Advocacy in the mental health setting may require mobilizing community and public sentiment and action in order to protect the rights of individuals, groups, and target populations who are socially and psychologically vulnerable. The values of the agency and those of the community regarding such issues as deinstitutionalization of mentally disturbed persons may be at odds. The consultant acting as advocate may establish linkages and networks, facilitate communication, and organize interventions.

While the nature of advocacy requires certain levels of knowledge, the strategies and skills required of consultants who act as advocates may already be in place, particularly if the consultant has been trained as a counselor. For example, advocates need skills in communication, organizing, problem-solving, facilitating groups, conflict management, empathy, negotiation and confrontation, careful listening, etc., and knowledge and understanding of human behavior.

Above all, the consultant-advocate should maintain values that demonstrate commitment to humans to be more important than commitment to existing values, systems or professional procedures, a dedication to learning what others may need and deserve and how to advocate for them; a realistic understanding of the demands and problems which may occur if the advocacy is pursued, and a concern for conflicts of interest and loyalties. It should be apparent that educating others to the needs and rights of a particular target group would require insight, strategy, commitment, and some risk taking.

Chapter Two

Empowerment Through Advocacy

Duane Brown

Counselors are regularly engaged in the process of directly assisting clients to mobilize their personal resources so that they can more effectively function in their environments. This direct process of personal empowerment is typically referred to as counseling. Less often, but frequently, counselors work indirectly to alter systems or to facilitate change in individuals which will result in enhanced personal functioning on the part of clients. This indirect empowerment process is termed consultation. In both counseling and consultation, the counselors assume a rather comfortable position, in that they subject themselves to very little risk. Clients and consultees may not become more effective, but the counselors can usually rest secure in the knowledge that they have provided the assistance sought. They are also relatively safe from criticism because, for the most part, the risks involved in counseling and consultation are assumed by the client and consultee, respectively.

Advocacy Defined

Advocacy often requires that counselors step out of the security of anonymity onto the real life stage of human relations in an effort to alter the power relationships that exist between organizations and the clients they serve. Advocacy, like counseling and consultation, is an empowerment process, that is, it is concerned with the transfer of personal power to the client. However, unlike counseling (and like consultation), it is usually an indirect method of assisting clients. And, unlike either counseling or consultation, the advocate often becomes the principal actor on behalf of the client.

Webster's *New World Dictionary* (Guralnik, 1984) defines an advocate as "One who pleads another's cause in support of something" (p. 10). This rather nebulous definition contains one important component; advocates act on behalf of others. However, it mistakenly suggests that an advocate represents only individuals. An advocate may work on behalf of an individual or a group. Furthermore, advocacy involves far more than pleading a cause. It involves the utilization of a whole repertoire of strategies aimed at assisting others (Morales & Sheafor, 1986).

Solomon (1976), writing about advocacy, adds still another dimension to our definition. He suggests that advocacy involves representing individuals in a stigmatized social situation to enhance their personal influence and to perform socially valued roles. Solomon's association of advocacy with assisting the oppressed and socially disenfranchised is echoed throughout the advocacy literature (Biklen, 1976; Conoley, 1981; Conoley & Conoley, 1982; Morales & Sheafor, 1986; NASW, 1969; Sosin & Caulum, 1983). While it is clear that there are advocates for the rich and powerful and, thus, advocacy is not solely restricted to assisting the disenfranchised, it is also clear that members of the helping professions have tied their advocacy activities to helping the less fortunate in our institutions, and in society generally.

The objective of advocacy is, generally speaking, helping the less powerful in our society gain those things that should be rightfully theirs in a democratic society. Sosin and Caulum (1983) describe advocacy as a process aimed at altering a decision or decision making process so that the welfare of interests of a less powerful group be served. Advocacy then has a focal point, whether it be an existing law or regulation or the process that promulgates statutes or policies. Advocacy for the downtrodden is a posture, but in the context of this discussion it is also a process that has an identifiable objective (or series of objectives) and, thus, an ending point. Its beginning point is the identification of an individual (or group) who has been deprived of their human or constitutional rights (Morales & Sheafor, 1986). However, Sosin and Caulum suggest that before beginning the advocacy process, the advocate should determine that there is a greater than zero chance that success is possible. In other words, advocates need to assess their chances for success before initiating an advocacy effort on behalf of a client.

As mentioned above, advocacy has a goal, helping the less fortunate in our society. Sosin and Caulum (1983) suggest that advocacy should not be aimed at correcting the power imbalance that resulted in the problem being experienced by the client. They believe that correcting a power imbalance is more properly termed a social movement. Perhaps this is true, but many (Biklen, 1976; Conoley & Conoley, 1982; Morales & Sheafor, 1986; NASW, 1969) appear to believe *correcting* the power balance is, indeed, one of the goals of advocacy. For Sosin and

Caulum, advocacy is changing a specific decision. This seems too restricted a goal for most advocates.

One final issue needs to be addressed: the role taken by the advocate in the advocacy process. Morales and Sheafor (1986) suggest that the advocate may either mobilize the client so that they can act on their own or intercede directly. While mobilizing the client seems like the most attractive alternative on the surface, when those in need of help from advocates, such as handicapped children, the aged and institutionalized, are considered, it is obvious that advocates will have to act directly on behalf of the client as the initial definition suggests (Guralnik, 1984).

In summary, advocacy can be defined as an empowerment process that is initiated whenever an individual or group is deprived of their human or constitutional rights. Its goals are to correct the decisions that led to the immediate social inequities and to prevent similar circumstances from occurring in the future, often by correcting a power imbalance that exists between the client and an organization or individual. While advocacy intervention strategies are varied, they basically involve assisting the individual or groups to intercede in their own behalf by helping them develop the needed skills, or interceding directly for them. There are six areas of advocacy practice, the first five of which were listed by Morales and Sheafor (1986). These are:

1. Family advocacy—Advocate typically represents the family initially, but has as his/her ultimate goal helping the family learn to deal with the system.
2. Agency advocacy—Advocate works on a board or within an agency to change conditions.
3. Legislative advocacy—Advocate attempts to influence legislation that empowers individuals or groups.
4. Ombudsmanship—Individual or agency corrects administrative grievances.
5. Brokerage—Advocate helps clients identify and link to resources (e.g., legal aide) that can assist them in dealing with grievances.
6. Community-based—Advocate works with community groups to assist them to mobilize for political action.

Qualities of the Advocate

While engaging in counseling, practitioners are often admonished to withhold or suspend their values, either during a part or all of the process, depending upon the model of counseling being employed. When acting as an advocate, counselors must make decisions based upon firmly held values and then initiate action based upon their values. Accordingly, counselors who expect to act as advocates must have a clearly articulated set of values, particularly as they relate to human and civil rights.

Conoley (1981) suggests that advocates must adopt what she terms a community imperative, based upon the premise that people are inherently valuable. Further, all people, regardless of their disability, socioeconomic status, ethnicity, physical condition, or level of intellectual functioning, have certain inalienable moral and constitutional rights which should not and cannot be abridged. These rights entitle them to opportunities that will allow them to maximize their potential in our society. Potential advocates would do well to search their value structure to determine whether they can wholeheartedly subscribe to this advocates' creed.

Chester, Bryant, and Crowfoot (1976) also suggest that, since the advocate is likely to be aligned with women, ethnic minorities, sexual minorities, and the poor, that the potential for value conflicts exists, particularly for the White, middle-class male. Regardless of gender, race, or socioeconomic class, advocates need to examine their values, not only to discern where they stand with regard to human and civil rights issues, but with regard to the groups that are disenfranchised in our society. Advocacy results in alliances that must be able to stand the strain of conflict. Values differences between the advocate and the group being represented can greatly reduce the possibility that the alliance will occur, let alone survive.

Advocacy is not for the timid. It requires personal and professional risk-taking beyond that experienced by most counselors filling their usual roles. It requires assertiveness in a sense somewhat different than standing up for one's own rights. Advocacy requires one to stand up for the rights of others, and while a sensitivity to the needs of the organization or individual who is the object of the advocacy is required, there is often a lower priority in the advocacy process. While the National Association of Social Workers (NASW, 1969) has admonished advocates to do no harm, Morales and Sheafor (1986) point out that "harm" will, in fact, be done to others in the sense that resources (e.g., food, housing, money) will be distributed differently or that power relationships will change. Because of the threat inherent in some advocacy processes, conflict will be the result. Advocates must be willing to accept the consequences of conflict, including personal and professional losses, such as loss of status or, in the extreme, loss of position.

At a minimum, then, advocates must have a clearly articulated set of values that allow them to espouse the importance of human civil rights. They must also have clarified their values to the point that they can enter into advocacy alliances with groups that are not in the mainstream of American society. Finally, they must be able to accept the personal and professional risks associated with advocacy. It may be helpful to the readers assessing their own qualifications for advocacy to recall the observation of Chester et al. (1976), who indicate that we are all advocates. Unless we are advocating for the oppressed and disenfranchised, we are unwittingly contributing to the

continuation of the position of the middle- and upper-class America. We advocate both by our action and our lack of it.

Skills and Strategies of Advocacy

Communications skills traditionally incorporated into counselor preparation programs are seen as essential in counseling and consultation, and are also important in advocacy situations. Few would argue with the proposition that perceiving the communication of others and communicating clearly in face-to-face situations are essential to the advocacy process. However, Conoley (1981) has set forth a number of other requisite skills and knowledge bases for successful advocacy. One of the latter is a clear understanding of the laws surrounding an issue and the legal processes needed to change a policy or statute are essential to successful advocacy. She also indicates that successful advocates possess the ability to (1) use the media to focus attention on an issue, (2) organize people, (3) write persuasively, (4) negotiate issues, and (5) use confrontation appropriately.

The use of media events to focus attention requires that advocates or one of their collaborators understand the workings of television and newspapers. Conoley and Conoley (1982) suggest that media events may include press conferences, public service announcements, leaflets, posters, appearances on talk shows, or newspaper articles. She also suggests that it is important to have contacts, such as sympathetic reporters in the media, if newspapers and television are to be used successfully.

Organizing people for advocacy efforts requires a special talent for identifying sympathetic reporters, identifying target groups, gaining the resources needed for the advocacy efforts, and then directing the efforts. This effort is not unlike that undertaken to organize fund raising efforts or political campaigns, and would-be advocates without these skills may wish to enlist the support of persons who have engaged in these efforts.

Writing persuasively probably needs little elaboration, other than to amplify three points. First, letters or other documents need to be succinct. Most persons, unless they are totally committed to a cause, will not spend long periods of time reading written communication. Second, key issues need to be highlighted. Modern political organizations, such as the conservative Congressional Club, use highlights throughout their communications. Third, letters should be from credible people. In the political arena, this usually means elected politicians who have a record for favoring a particular cause. In a school district where advocates are trying to persuade the school board to increase taxes so that more services can be provided to low-achieving children, a leading citizen might be enlisted to write the letter.

Johnson and Johnson (1982) suggest that negotiation begins with confrontation, which they define as "the direct expression of one's view of the conflict, and one's feelings about it and at the same time an invitation to the opposition to do the same" (p. 301). They go on to indicate that confrontation should be aimed at directing the attention of both parties toward problem resolution. Johnson and Johnson present several specific guidelines for effective confrontation.

1. Confront only when both parties have an opportunity to jointly define the problem at hand
2. Communicate your feelings in non-threatening ways
3. Make every effort to fully comprehend the adversary's point of view.

Once confrontation has taken place, the two parties involved should define the conflict as a mutual problem, clearly communicate their positions and feelings about all aspects of the problem, communicate intentions to cooperate in problem solving to the extent possible, and to bargain in good faith, once that process is set in motion. In all negotiations, avoid a win-lose approach whenever possible, that is, attempt to devise solutions where both parties attain one of their goals (Johnson & Johnson, 1982).

Sosin and Caulum (1983) stress that the same strategies are not employed in every advocacy situation. They suggest that whenever there is an adversarial situation, that is, the advocate and the decision makers hold vastly different views and the advocate has little legitimacy, that coercive strategies are called for. These strategies "rely on conflict, dissent and complaint" (Sosin & Caulum, 1983, p. 15). Presumably, most of the techniques identified by Conoley (1982) could be employed in adversarial situations, but confrontation, mobilizing public sentiment, forming pressure groups, and writing persuasive arguments, would certainly fall into an overall adversarial approach to advocacy.

Utilitarian strategies are employed whenever the relationship between the advocate and the decision maker is neutral (Sosin & Caulum, 1983). This occurs whenever the advocate has the same credibility as other persons in a situation. In the adversarial situation, power is fought with power and emotions may run high. In neutral situations, the attitude of the decision maker may well be to side with the most persuasive argument. As a result, presenting systematic arguments, bargaining and systematic negotiation are the skills needed in this situation.

The third situation that may exist is that the advocate and the decision maker are in essential agreement about the nature of the problem and, thus, normative strategies are called for. Normative strategies involve mobilizing what is a widely-held view, so that a change in a decision or a particular course of action can be legitimized. Again, the use of media and writing persuasive position statements would appear to be valuable skills.

Conoley (1982) seems to take the position that there is a set of basic skills needed by advocates. Sosin and Caulum (1983) stress the importance of wedding the correct strategy to the advocacy context. Still another way to look at the skills required by advocates is to consider areas of advocacy practice. As noted in the definition of consultation, there are at least six types; (1) family advocacy, (2) agency advocacy, (3) legislative advocacy, (4) ombudsmanship, (5) brokerage, and (6) community-based.

Nulman (1983) suggests that the individual who expects to function as an advocate for families must have specific skills. Levy (1970) suggests that these might be the ability to assist the family to identify their needs and to identify strategies by which those needs might be met. It may also mean acting for the family and initiating efforts to secure policy changes that will benefit a particular family or a number of similar families.

Agency advocacy involves working around or within an agency to initiate change that will meet the needs of a client. One school counselor ran and was elected to the school board which automatically gave her a platform to advocate a number of positions. But simply being elected or appointed to board of governmental body does not ensure effective advocacy. Advocates need to know the history of issues, determine the forces that contribute to the current situation, collect data about the extent of and impact of policies on a particular group, determine the position of other agency members on an issue at hand, and then establish strategies to bring about changes.

Legislative advocacy is a type of advocacy that many counselors understand, because they have been involved in the process directly. However, for the uninitiated, Dear and Patt (1981) offer guidelines for being successful in the legislative arena. These are:

1. Introduce legislation before legislative session begins or at the outset of a legislative session
2. Get multiple sponsors for the bill
3. Obtain sponsors from the majority party
4. Conduct lobbying efforts to broaden the support for the legislation
5. Seek support from influential legislators
6. Press for open committee hearings
7. Use the amendment process to promote a favorable outcome.

Inherent in Dear and Patt's (1981) seven points is Conoley's (1981) dictum that advocates must understand the legislative process. Fortunately, the American Association for Counseling and Development and its divisions have produced a great deal of information that can facilitate this understanding.

Ombudsmanship is also a type of advocacy reasonably well-understood by a number of counselors, particularly those that work on

college campuses where student advocates are employed. Essentially, the task of these troubleshooters is to help students with administrative grievances gain satisfaction. Such problems as in-state vs. out-of-state tuition, housing assignments, registration miscues, grading problems, and other similar problems, fall into the purview of the student advocate. These advocates need to understand the administrative structure of the college or university, how to access that structure to solve a specific problem, and the processes that must be followed to solve problems. The primary skills required, in addition to those already listed are bargaining and negotiation with various administrators.

Many counselors act as advocates by performing a brokerage or resource linkage function. School counselors, often forbidden by policy to dispense birth control information, provide linkages between students and public health clinics, or in some instances, with abortion clinics. Similarly, counselors provide linkages between families and community agencies or between students and lending agencies. The skills required to perform this type of advocacy are relatively simple. Counselors must be able to develop a list of resources that can be of assistance to their clients and be able to make successful referrals.

Community-based advocacy falls squarely into the area of facilitating community action or, in other instances, leading the political activity. Conoley's (1981) skills of organizing and mobilizing people, using media to focus attention on an issue, and writing persuasively are needed by advocates in this area. This type of advocacy, along with agency and family advocacy, are probably the least familiar to counselors, even though some counselors are engaged in advocacy efforts in each of these categories.

While the foregoing list of skills and strategies may be a starting place for inventorying one's advocacy skills, it is worth noting that not all advocates focus on the area of mass media and dramatic confrontation. Many school counselors are quiet advocates for students who are disenfranchised by unfair school policies. For example, one counselor, concerned because a large black student population was not represented in the Honor Society, quietly stated the students' case to each member of the faculty advisory committee that set the policies governing the organization, and then laid out her case in their initial meeting. She argued that black students in this particular community often did not receive the initial parental support for educational achievement as did their white peers. As a consequence, many came to the high school with some deficits and, thus, while being high achievers by the junior and senior year did not have the grade point average established as the minimum requirement for the Honor Society. The result was that the advisory committee changed the admission policy to admit students who had made significant and substantial gains in their achievement.

A mental health counselor in private practice became an advocate for an abused child in a family that he was seeing who was not removed from the home by the Department of Social Services (DSS). The child was, in the counselor's view, in danger in injury or death from an abusive parent. The DSS disagreed and refused to act. After repeated and pointed explanations about the danger to the child, the counselor took the case to a district supervisor who convened a meeting of all parties involved to review the case. The result was that the child was temporarily placed in a foster home.

Advocates can, and do, use strategies that require nose-to-nose confrontation and face-to-face problem identification. They may become involved in difficult negotiations or collaborative planning. Persuasive strategies, such as newspaper articles, may be employed, or the client's case may be simply stated to an otherwise unaware listener. In summary, there is no stereotypical advocate; there are only counselors who care about their clients and find that their traditional methods of helping are either not useful or not fast enough, given the nature of the client's problem.

The Process of Advocacy

Advocacy begins whenever an individual or group is identified that has been deprived of their human or civil rights. This might be a group of students who are deprived of due process whenever charged with school offenses. It might mean street people who do not have adequate food or shelter. A group of elderly people who have inadequate health care might also be the basis for beginning an advocacy process.

As noted earlier, Sosin and Caulum (1983) recommend that the advocate estimate the probability of success before proceeding, and, if it is zero, not to proceed. It is quite difficult to estimate the probability of a successful advocacy effort. However, the nature of the identified problem may be a more important factor in making a go—no go decision. First, the severity of the problem should be considered. Life-threatening conditions require immediate action, regardless of the probability of succeeding. So do situations where civil rights are being abridged in a fashion that will have a deleterious impact on the client or group. Handicapped children or persons being deprived of opportunities for appropriate educational opportunities are examples of situations that indicate advocacy is imperative. Less severe, temporary problems that have little or no long-term consequences may need to be ignored, simply to maintain the credibility of the advocate. The quixotic advocate who pursues every cause runs the risk of becoming ineffective.

Once a problem is identified, a key question becomes who should decide whether to initiate the effort? Sosin and Caulum (1983) suggest that a majority of authors writing in this area agree that it is the advocate who should decide. They also suggest that the client may

decide, or that a decision to proceed can be reached collaboratively. When one considers that advocates are likely to be representing children, the infirm, the incarcerated, the poor, and other similar groups, the position that the advocate should make the decision to proceed makes a certain amount of sense. However, the physical and intellectual functioning of the client may well come into play in determining who makes the decision to proceed.

Small children, the mentally ill, and certain groups of retarded and physically ill persons (e.g., those with brain damage) are in no position to assess their personal situation and participate in the decision making process. Other groups are able to do so, and should be included. Often, the disenfranchised are fearful of the consequences of an advocacy effort, and with good reason in some instances. However, the advocate must assess, with the client, the severity of the problem, the possible consequences of not trying to initiate change, and the potential problems that may accrue if an advocacy effort is initiated. Then, a decision should be initiated.

There are times when the client's decision not to engage in an advocacy effort should be overruled, particularly when the consequences of not acting are severe. Given this caveat, clients who are capable of comprehending the consequences of inactivity should be granted the right to remain in their current situation.

Once a decision is reached to pursue an advocacy process, target persons or groups must be identified. What are the policies or practices that have resulted in the client's situation? Who promulgated those policies, or is engaged in those activities? What are the processes that must be followed to change a policy, regulation, or statute? How can a target person be influenced? Is the target an adversary, an ally, or are the persons involved neutral with regard to the matter at hand? In answering these questions, the advocate may need to include others who are aware of the problem and who are interested in resolving it.

The actual level at which an advocacy effort will be pitched will be, to some extent, determined by the nature and locality of the persons who are being victimized. One family, wrongfully deprived of decent housing does not suggest the need for a massive effort. Numerous people being systematically deprived of their civil rights suggests something far different. A rule of thumb in this area is that the advocacy effort should be initiated to minimize the amount of resources needed to solve the problem. If one visit to one person will be sufficient, then that should be the advocacy strategy. If a political coalition is necessary to change a school board policy, then advocacy should take that course.

If numerous people are to be involved in the advocacy effort, it is suggested that strategy selection be conducted by the broader group. Advocacy efforts offer many opportunities for conflict within the advocacy efforts and involving the entire group in the strategy can eliminate one area of potential difficulty.

Ethics and Advocacy

Numerous authors and groups (e.g., Morales & Sheafor, 1986; NASW, 1969; Nulman, 1983; Shanker, 1983) have attested to the fit between advocacy and the ethical position of social workers. The ethical support of advocacy is not as clear, but is there nonetheless. The newly revised National Board for Certified Counselors Code of Ethics (NBCC, 1987) has been chosen to illustrate the ethical underpinnings of the would-be counselor-advocate. On page 1, Section A of that document, the following statement appears:

The acceptance of employment in an institution implies that the certified counselor is in agreement with the general policies and principles of the institution. Therefore, the professional activities of the certified counselor are in accord with the objectives of the institution. If, despite concerted efforts, the certified counselor cannot reach agreement with employers as to acceptable standards of conduct that allow for changes in institutional policy that are conducive to the positive growth and development of clients, then terminating the affiliation should be seriously considered.

As is obvious, this statement begins by talking about the fact that the counselor is in general agreement with the policies and develops programs that follows its objectives and ends with a statement regarding making concerted efforts to change policies that do not allow for growth and development. Counselors would be on firmer ethical footing if the NBCC and other codes of ethics relating to counseling simply asserted that counselors have their first responsibility to promote and protect the welfare of the client in all situations.

Another ethical problem for counselor-advocates is that there are no general ethical outlines for the advocate, either in the NBCC (1987) code or in other codes of ethics. In Section E, Consulting, the certified counselor is admonished to encourage client adaptability and growth, but nowhere in this code or the others available (e.g., Ethical Standards of the American Association for Counseling and Development) are the general ethics of the advocate addressed. For example, it has been suggested that advocates may proceed on their own initiative under certain circumstances. This recommendation is in opposition to guidelines for proceeding in either counseling and consultation. Without this guideline, the would-be advocate is not only without professional direction, but vulnerable to legal action, because of violation of typical standards of care in the counseling profession.

If advocacy is to become a regular part of counselors' functions, some consideration needs to be given to revising existing codes of ethics to include ethical principles pertaining to advocacy.

Some Problems in Advocacy

Conoley (1981) identified four problems for the would-be advocate: (1) gaining the support of your institution, (2) avoiding crisis in one's institution, (3) being made a scapegoat, and (4) exploiting a client group for personal gains. To Conoley's list should be added a fifth problem, the possibility that upward mobility in the system may be stymied.

Many administrators operate from a premise that conflict is harmful to the organization. Whether this perception grows out of a concern for their own position if conflict erupts, or a firmly-held belief in the need to eliminate conflict, is unclear. What is certain is that these administrators are not going to be supportive of individuals who cause conflict. Would-be advocates should work to clarify the nature of the organizational stance on advocacy and attempt to gain support based upon the need to represent client groups satisfactorily.

Over-zealous advocates may, unwittingly, throw an institution into crisis by mobilizing forces to oppose policies and practices. While, in some instances, this may be necessary as a last resort, client groups may be inadvertently harmed by these crisis situations and, thus, as Conoley (1981) suggests, advocacy efforts should be launched in a manner to avoid this possibility.

The advocate may become a scapegoat for both sides in an issue, particularly if there is not a firm commitment to action by the client group. If this is the case when heavy opposition occurs, the client group may simply withdraw, leaving the advocate "holding the bag" and, thus, susceptible to the charge that there was never really an issue. Gaining commitment from the client group and support from the employing institution can greatly reduce the possibility of becoming the scapegoat.

Ethically, counselors are to place client needs first. However, when an advocate has built a powerful coalition, it is tempting to use it for personal gains. Needless to say, this should be avoided.

Counselors with ambitions to scale the organizational ladder endanger those ambitions unless there is administrative support for advocacy. Some institutions have established advocacy offices (e.g., ombudsmen) which is the ultimate in institutional support. But even in these situations, advocates may make powerful enemies that will block upward mobility.

Summary

Advocacy is a role filled by many counselors. However, it is a role that has not been widely discussed in the counseling profession. The result is that there are few guidelines for advocates, particularly in the ethical area. This presentation has been an attempt to provide an overview of the process and practice of consultation. There are special skills which, if mastered, can enhance one's chances of success in

advocacy efforts. The would-be advocate should master these skills before proceeding. There are also differential strategies that need to be learned which pertain to the nature of the target groups that need to be considered before launching an advocacy group.

Advocates are vulnerable to personal and professional losses. They are also capable of making tremendous gains for their clients when other strategies employed would be ineffective.

References

- Biklen, D. (1976). Advocacy comes of age. *Exceptional Children*, 43, 308-311.
- Chester M. Bryant, B.I., Jr., & Crowfoot, J.E. (1976). Consultation in schools: Inevitable conflict, partisanship and advocacy. *Professional Psychology*, 6, 637-645.
- Conoley, J.C. (1981). Advocacy consultation: Promises and pitfalls. In J. C. Conoley (Ed.), *Consultation in schools: Theory, research, and procedure*. New York: Academic Press.
- Conoley, J.C., & Conoley, C.W. (1982). *School consultation: A guide to practice and training*. New York: Pergamon.
- Dear, R.B., & Patt, R.I. (1981). Legislative advocacy: Seven effective tactics. *Social Work*, 26, 289-296.
- Guralnik, F. (1984). *Webster's new world dictionary*. New York: Warner Communications.
- Johnson, D.W., & Johnson, F.P. (1982). *Joining together: Group theory and group skills*, (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.
- Levy, C.S. (1970). The social worker as an agent of policy change. *Social Casework*, 51, 101-104.
- Morales, M., & Sheafor, J. (1986). *Social work: A profession of many faces* (4th ed.). Newton, MA: Allyn & Bacon.
- National Association of Social Workers (1969). The social worker as advocate: Champion of social victims. *Social Work*, 14, 18.
- National Board for Certified Counselors (1987). *National Board for Certified Counselors code of ethics*. Alexandria, VA: NBCC.
- Nulman, E. (1983). Family therapy and advocacy: Directions for the future. *Social Work*, 28, 19-22.
- Shankar, R. (1983). Occupational disease: Workers compensation and the social work advocate. *Social Work*, 28, 24-27.
- Solomon, B.S. (1976). *Black empowerment: Social work in oppressed communities*. New York: Columbia University Press.
- Sosin, M., & Caulum, S. (1983). Advocacy: A conceptualization for social work practice. *Social Work*, 28, 12-17.

Chapter Three

Consultative Advocacy Differentiated From Legal Advocacy

Theodore P. Remley, Jr.

Attorneys and consultants take a different view of advocacy. For lawyers, advocating their client's position is their reason for being. While advocacy is an ethical responsibility of an attorney, it is not a position required of consultants. Advocacy is only one of the roles available to consultants. Because an advocacy posture often conflicts with the requirement that consultants remain objective, it should be assumed with caution.

Although many other roles for consultants have been defined (Brown, Pryzwansky, & Schulte, 1987; Caplan, 1970; Dear & Patt, 1981; Morales & Sheafar, 1986), organizational development consultation is an area that has interested a number of contributors to the literature (Argyris, 1970; Bennis, 1966; Lewin, 1951; Lippitt, 1982; Morasky, 1982; Schein, 1969). This exploration of issues for consultants who choose to become advocates will focus on consultation within an agency environment.

Attorneys as Advocates

While consultants may choose to become advocates, advocacy is an ethical requirement for attorneys. Members of the legal profession have no difficulty defining their role within a system. If they are retained by an agency, they must help the agency accomplish its objectives. Conversely, attorneys are hired by individuals who work for an agency, they must assist the individuals in achieving their goals.

The organization paying the fees dictates the allegiances of lawyers. For example, attorneys representing a corporation in a labor dispute research the corporation's position, review that position within a legal context, and do their best to insure that the views of the corporation prevail. On the other hand, attorneys hired by a labor union investigate the union's point of view, determine whether the position has a legal foundation, and vigorously argue for their client's perspective. An attorney's role does not allow judgment as to the appropriateness of a position taken if it is legally defensible. Lawyers do not apply their values to their client's points of view, providing of course, that their clients have a legal foundation and a legal right to their positions.

For lay persons outside the legal profession, advocacy of a position within a controversy based on who is paying the fee is distasteful. This aversion to the lawyer's advocacy role is a result of either a misunderstanding or a rejection of our country's adversarial legal system.

In the United States, when two individuals or entities are unable to resolve disputes between themselves, they have available to them the court system. In a court of law, parties present their cases as persuasively as they can. They hire attorneys to argue their points of view. Often, both are legal, but one must prevail over the other. Attorneys who act as advocates in court have the ethical responsibility of presenting their client's position in a manner that will convince a judge or jury that the client's point of view should prevail. Attorneys do not pass judgment on their client's positions if a legal basis exists. Rather they simply do their best to help their clients prevail.

Consultants as Advocates

It is clear then that consultants who find themselves in advocacy positions must behave differently from the model of advocacy provided by the legal profession. If consultants are not supposed to take up the position of their employer and vigorously promote it, what then is their advocacy role?

Lawyers, if they are satisfied that their client's position is legal, do not judge whether the wishes of the client are beneficial to the client or to others. Consultants, however, have an obligation to help a system or agency function ethically and more effectively. Kurpius (1985) and Beer (1980) have provided guidelines useful to consultants as they consider different intervention possibilities. In many instances, the consultant's job is to evaluate relationships, analyze procedures, and look at the various components of an organization to identify problems. The role of all consultants is potentially judgmental. When consultants identify changes that need to be made, it is their responsibility to help the agency or system achieve these beneficial changes. Assuming that ethics are not compromised in any way, consultants are relied upon to have the best interests of the system

foremost in their minds. The desires of individuals and the goals of an organization are secondary for consultants to the overall effectiveness of a system. Consultants cannot afford to be blind advocates of a position because they must evaluate every point of view to determine whether each is beneficial to the system to which they owe their obligation.

In some instances consultants may need to empower individuals within an organization for its benefit. In other situations, consultants may need to help the system decrease the power some individuals hold for the welfare of the organization.

Advocacy Power of Consultants

The general power of consultants within a system is significant. If consultants use this power for advocacy, they have the potential for furthering the position of the individuals or of the system favored.

Strangers seldom are brought into agencies to evaluate the functioning of the organization unless they are viewed as experts who have special knowledge and skills to contribute. This expert status gives considerable weight to the ideas of consultants. Despite the perspective held by most consultants that consultative relationships should be egalitarian (Brown, Pryzwansky, & Schulte, 1987), consultants generally are viewed as experts by those who retain them.

All individuals within society who have power must be careful to exercise it in an ethical manner. Consultants have a responsibility to dedicate themselves to the betterment of a system. They must put aside their own personal needs, avoid being unduly influenced by the wishes of individuals with an agency, and acknowledge the desire for control some managers within a system might possess.

Aside from the power inherent in a consultant's status, additional power is available to consultants who are brought into an agency from the outside because change is desired. Because they are expected to effect change, outside consultants have an advantage within an organization that is not available to regular participants. When they suggest change, their motives are not questioned because it is their role to introduce differences. It is vital, then, that outside consultants recognize this added potential influence and use it only if it benefits the agency as a whole.

Effective consultants know themselves well, understand their personal value system (Kelman, 1965), are comfortable with the responsibility they owe to a system, and are capable of resisting pressure to advocate any position they feel is inappropriate to the well-being of an agency.

Dangers in Advocacy

When controversy exists within an agency, consultants who take on an advocacy role can easily exacerbate problems that already are present.

Individuals or groups who hold opposing viewpoints often are polarized by the time a consultant is brought into an agency. Consultants who enter such situations and become advocates for either side are asking for disastrous results. Seldom in a conflict is one side absolutely right and the other undeniably wrong. It is much more appropriate in controversial situations for consultants to keep in mind their primary obligation to the agency and attempt to move both opposing sides to a position that will benefit the agency overall without favoring one side over the other.

In some instances, it may be judicious for consultants to take positions that are less attractive in an effort to maintain their goal of objectivity. For instance, if a consultant feels group A has a better position than group B in a given controversy, it may be better for the consultant to avoid taking a position or to develop a middle stance that is acceptable to both even if it is less attractive than the position of group A to the consultant. When consultants lose the confidence of either side of a controversy, their effectiveness in the consultation process is diminished or generally negated.

Objectivity is essential for consultants. Moreover, the appearance of objectivity is fundamental if a consultant is to be effective in an agency torn by conflict. Any positive contributions consultants have to offer will be ignored if they are not able to maintain the confidence of the agency members.

Appropriate Advocacy Roles for Consultants

Despite the potential problems inherent in assuming advocacy roles, it often is necessary for consultants to become advocates if they are to perform their responsibilities effectively and ethically. Consultants cannot ignore illegal, unethical, or counterproductive activities in an agency. Since the agency or system is the client, consultants must address problems that could contribute to the ineffectiveness of an organization.

Examples of situations in which consultants must assume advocacy roles are examined below. Guidelines are provided for the positive resolution of each issue.

Empowering Individuals

Problem. You have been hired by a community mental health center to evaluate its program and recommend any necessary changes because the center will be reviewed soon for accreditation.

After spending some time in the center and after talking to several administrators and staff members, you come to the tentative conclusion that staff mental health counselors are being discriminated against in the center's salary system, decision-making process, and work schedule. Social workers, psychiatric nurses, psychologists, and psychiatrists in the center generally have better working conditions and do not want any changes to be made.

It is obvious to you that a great deal of resentment has developed over time because of the differential treatment of mental health counselors and that this resentment is affecting the functioning of the mental health center in a severely negative fashion.

Guidelines. First, it is essential that you recognize your own biases and examine them before you explore solutions to this problem. If you are a mental health counselor who has felt some discrimination from other mental health professionals in the past, it is vital that you put aside your own feelings that might lead you to be motivated by something other than a desire to help this center perform its function most effectively. You must be careful not to use this situation to make a broad statement for nondiscrimination against mental health counselors. You must not be tempted to use your potentially powerful position as a consultant to rectify wrongs that have been inflicted upon you in the past. Instead, you must attempt to put aside your identity as a mental health counselor and look at this situation in as objective a manner as possible.

You must decide whether advocacy is appropriate in this particular situation. It is wise any time a consultant is considering taking on an advocacy role first to consider carefully alternatives that would not require acting as an advocate.

It is important for consultants to consider many alternatives when addressing problems within an agency, even when the solutions seem unacceptable at first. Some of the possible recommendations you could make in this situation that would not require you to become an advocate include: (1) eliminating the mental health counselors from the center staff since the other mental health professionals seem to be working well together; (2) suggesting that the center bring in a mediator to attempt to resolve the differences within the staff; or (3) reporting the problem in your final analysis without attempting to resolve it.

Keeping in mind your responsibility as a consultant to the welfare of the agency and those it serves, you could come to the conclusion that your only realistic alternative is to become an advocate for the mental health counselors in this center if the agency is to resolve its problems.

Your goal then would be to help change the procedures in the center in such a way that the mental health counselors would be treated fairly. If you decide on this course of action, you must be sure to present every recommendation you make in the context of doing what is best for the center as a whole. If, at any point, the other professionals in the center decide you are blindly biased toward the mental health counselors, your effectiveness as a change agent will have been lost.

Removing Power from Individuals

Problem. You have been retained to review the guidance program of a large urban school system. The superintendent has asked that you

review the program because a recent evaluation-report revealed that parents, teachers, and principals in the system were generally dissatisfied with the guidance program.

You discover in your study of the guidance program that the 45 counselors in the system do not like the developmental focus of the new system guidance supervisor. The supervisor is requiring the counselors to become more involved in classroom guidance activities, see parents in the evenings and on weekends, decrease the number of individual appointments they have with students, and focus more of their program on career development. Before the new supervisor arrived the year before, there had been no guidance supervisor in the system and the counselors had developed and maintained their own programs with no oversight from the central administrative office.

Guidelines. As in the first problem, it is important that you acknowledge any biases you may have before you begin looking for solutions to this difficult situation. You may feel quite strongly that this new guidance supervisor has introduced positive and innovative changes to the guidance program in the district and that the counselors are wrong in not adapting themselves to their new responsibilities. You should not let this initial judgment influence your actions, however, until after you have considered many possible alternatives.

It will be important that you consider possible solutions to this situation that will not require you to become an advocate for the guidance director. Some alternatives that would avoid this problem include: (1) eliminating the new guidance supervisor position and allowing the counselors to resume their autonomy; (2) reducing the influence the supervisor has on the counselors and making the role of the supervisor more of a coordinator rather than a leader, or (3) identifying the problem with no opinions expressed regarding the appropriateness of the new supervisor's program and with no suggestions for resolution.

If you determine, however, that you must address this issue for the good of the system in a way that will support the new guidance supervisor, you must find an approach to accomplish this goal that will not alienate the counselors. If the counselors feel as if you are siding with the supervisor and rejecting their position, you will have little chance to implement positive change as a consultant.

Unethical or Illegal Practices

Problem. You are hired as a consultant to a for-profit counseling organization in a large city. The agency retains you to suggest strategies for increasing referrals from local physicians.

As you begin to investigate the current source of clients coming into the counseling agency, you discover that they are referred by psychiatrists who have a questionable arrangement with the agency. The psychiatrists are referring their patients to the agency but

continue to indicate to the health insurance carriers of the patients that the psychiatrists are providing counseling services. The psychiatrists have an arrangement with the agency for counselors in the agency to provide counseling services to these patients and for the psychiatrists and the agency to split the money that comes in from the insurance carriers. It becomes obvious to you that the agency has retained you to figure out a method for them to develop similar unethical and illegal arrangements with other psychiatrists.

Guidelines. In some instances, a consultant may be forced to become an advocate for the profession rather than an advocate for individuals within an agency.

A moralistic reaction probably is inappropriate as an initial response in this situation. You might attempt the following strategies:

(1) Try to conceptualize a way in which the agency could continue to function successfully without engaging in the present unethical arrangements with the psychiatrists. A possibility would be for the agency to hire a staff psychiatrist who would supervise all clinical services so that insurance payments could continue to come into the agency. Insurance forms would have to be completed in a manner that discloses that the staff psychiatrist supervises and another individual renders direct services. All referring psychiatrists might be offered such part-time supervisory positions. This would be a legal and ethical way to continue patients receiving insurance reimbursement for mental health services without deceiving insurance companies about the identity of the direct service providers.

This option might be presented to the agency. This concept would allow the agency to continue its present practice in a way that is acceptable to the profession.

This approach is preferable to confronting the agency officials with their inappropriate actions and accusing them of unethical and illegal activity. Such a confrontation would alienate the administrators and render you ineffective in your consultation role. If a plan such as this is unacceptable to the agency, another method to address the problem must be developed.

(2) An alternative way for the agency to accomplish its objective using psychiatrists might be for the agency to be presented with a plan that would allow them to operate successfully without referrals from psychiatrists. This might involve a new and innovative approach to the delivery of mental health services for the agency. The key would be to introduce this new model for operation without criticizing the one you would be hoping to replace.

(3) If neither of the plans above were acceptable to the agency, you might have to simply confront the administrators with your determination that their arrangement with the psychiatrists is unethical and illegal. Such a confrontation probably would result in your termination as a consultant. However, you should offer to continue your relationship in order to work cooperatively with the agency in seeking an acceptable solution to the problem.

Conclusion

Advocacy is a function that is appropriate for various professionals as they provide services. Attorneys act as vigorous advocates of the positions of their clients and have no responsibility to evaluate the appropriateness of these positions. Consultants, on the other hand, occasionally are forced to become advocates as they attempt to assist agencies resolve problems. However, consultants must always bear in mind that the agency itself is the primary focus of the consultation — even when they become an advocate for an individual, a group of individuals, the administration, or the profession. Any advocacy activity of a consultant must have the agency's welfare as the only motivator for such action.

A consultant who becomes an advocate must continually be aware of the dangers inherent in assuming the role. In situations in which it is necessary for the consultant to become an advocate, the consultant must avoid contributing to the conflict that already exists within a system.

Advocacy is not a preferred approach for consultants because their responsibilities demand objectivity and a clear focus on the well-being of a system. However, in order to serve the system or agency well, a consultant may occasionally have to become an advocate for individuals or ideas within an organization.

Consultants who find they must become advocates should examine their motives to be sure they are not advocating an idea or position because it serves their own needs or purposes. When advocacy becomes necessary, the consultant must be careful to keep the best interests of the agency in mind and continually communicate this orientation to those involved.

Consultants cannot avoid advocacy responsibilities if a situation demands they take on an advocacy role for the welfare of an agency. However, consultants should be aware of the inherent difficulties an advocacy posture presents and have an obligation to avoid inappropriate advocacy roles.

References

- Argyris, C. (1970). *Integrating the individual and the organization*. New York: John Wiley & Sons.
- Beer, M. (1980). *Organizational change and development: A systems view*. Santa Monica, CA: Goodyear.
- Bennis, W. (1966). *Changing organizations*. New York: McGraw-Hill.
- Brown, D., Pryzwansky, W.B., & Schulte, A.C. (1987). *Psychological consultation*. Newton, MA: Allyn & Bacon.
- Caplan, G. (1970). *The theory and practice of mental health consultation*. New York: Basic Books.
- Dear, R.B., & Patt, R.J. (1981). Legislative advocacy: Seven effective tactics. *Social Work*, 26, 289-296.

- Kelman, H.C. (1965). Manipulation-of human behavior. *Journal of Social Issues*, 21, 31-46.
- Kurpius, D.J. (1985). Consultation interventions: Success, failures and proposals. *The Counseling psychologist*, 13, 368-389.
- Lewin, I. (1951). *Field theory in social science*. New York: Harper & Row.
- Lippitt, G.L. (1982). *Organizational renewal* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.
- Morales, M., & Sheafor, J. (1986). *Social work: A profession of many faces* (4th ed.). Newton, MA: Allyn & Bacon.
- Morasky, R.L. (1982). *Behavioral systems*. New York: Praeger.
- Schein, L.E. (1970). *Organizational psychology* (2nd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Chapter Four

Consultation As Advocacy And Outreach In Community Mental Health Settings: Theory To Practice

Gordon Gibson

Practitioners in human service delivery systems often find themselves in situations requiring them to become either an advocate for troubled, vulnerable, sometimes disinherited individuals and groups or an enforcer of the community sociocultural norms, in addition to fulfilling their usual caregiving responsibilities. In these situations the service provider has the opportunity to improve the competency of the community service setting, community support systems, or other organizations and institutions related to the vulnerable individuals. This activity is generally called consultation as opposed to counseling or other direct caregiving transactions. Consultation in the field of mental health has become quite diverse since the first published reports of the effects of mental health consultation thirty years ago (Eisenberg, 1958; Mannino, MacLennan, & Shore, 1975).

Development Of Theory Of Consultation: Advocacy And Outreach

Systems Theory of Consultation:

The earliest theory of mental health consultation was developed by Caplan through the Laboratory of Community Psychiatry at Harvard University. Caplan's definition of consultation has been the basic model for consultation practitioners in community mental health:

Consultation is used in a quite restricted sense to denote a process of interaction between two professional persons—the consultant, who is a specialist, and the consultee, who invokes the consultant's help in regard to a current work problem with which he is having some difficulty in which he has decided is within the other's area of competence. The work problem involves the management or treatment of one or more clients of the consultee, or the planning or implementation of a program to cater to such clients (Caplan, 1970, p.19).

The practice of mental health consultation in community settings has required the importation of perspectives from systems theory, organizational development theory, and community psychology. From the systems and organizational perspectives Argyris (1970) and others (Friedlander & Brown, 1974; Kurpius, 1979) have described the importance of the consultants' independence from their recipient systems as they design and conduct interventions: "[the consultant] assists a system to become more effective in problem solving, decision making, and decision implementation in such a way that the system can continue to be increasingly effective in these activities and have a decreasing need for the [consultant]" (Argyris, 1970, p. 16).

Behavioral Theory of Consultation

From the perspective of behavioral psychology a social change model has emerged whereby the reinforcement contingencies are developed or modified to shape the culture and environment of individuals in their groups, organizations, or communities (Krasner, 1980; Nietzel, Wiatt, MacDonald, & Davidson, 1977; Price, 1974, & Wicker, 1974). Behavioral principles have been utilized to increase the frequency of generally accepted desirable community behaviors including more use of shared transportation (Foxx & Schaeffer, 1985), increased citizen participation and governing of community boards (Briscoe, Hoffman, & Bailey, 1975), as well as in other natural environments (Tharp & Wetzel, 1969). The major limitations to the use of behavioral principles have been in situations requiring control of larger environments or the larger community. The consultant generally is unable to control the reinforcement contingencies prevailing in the larger community. Even working through key community leaders, service providers, and organizations behavioral consultants are presented with situations where they are unlikely to have control over the reinforcers for these community mediators. The more common criticisms of the outcomes of behavioral interventions have come from those community psychologists who have observed cases of effective behavioral management of the problem behaviors of the "troubled" individual while not addressing the community's reinforcement contingencies that produce and maintain those problem behaviors (Holland, 1978).

Community Psychology Theory of Consultation

The field of community psychology has developed the perspective of a more assertive social change or advocacy role for consultation in community settings. In a review of multiple types of community intervention methods, Heller has incorporated social change into the definition of consultation in community settings.

Consultation refers to an approach to social change through improvement of existing community organizations and institutions. The goals of consultation are modification, renewal, and improvement (Heller, Price, Reinhartz, Riger, Wandersman, & D'Anunno, 1984, p. 231).

Until the past decade mental health consultation simply had not incorporated other theoretical models which took into account the individual's interface with his/her environment. The mental health field has been dominated by counselors and clinicians who have been oriented more toward individual and small group interventions. Caplan's (1970) typology of consultation is oriented toward intervention with either individual or organizational problems. As community psychology has developed Caplan's model has been expanded to include community problems with interventions focused on the community and community support systems (Gibson, 1976).

Community psychology theorists recognize the need for individual and organizational interventions. The dilemma, however, is for the situation in which the need or opportunity for intervention is more appropriately at a community or societal level. Rhodes (1972) has described this dilemma as a threat-recoil situation in which the community is initially threatened by a set of problem behaviors, either incipient or actually observed, and then subsequently sets about utilizing or developing protective barriers to alleviate the stress. These community barriers, which are the community human services and power structural systems, function as buffers between the sources of threat and the community responders.

In the past, these buffers, whether educational, social welfare, legal-correctional, or mental health, viewed the problem behavior or threat as a "private misery" or individual problem which if not readily resolved, would require removal from the community. Historically, consultants representing any of these systems simply did not question the environmental setting, that is, the group, organization, or the community in which the individual was embedded. Following a period of assessment, treatment, and evaluation in one of the programs or facilities of the buffer systems—a state mental hospital, a corrections facility, or an alternative special education program, some individuals could return to the community setting. The advocacy issues have revolved around the differences in individual behavior and how their communities have responded to these. The more the unique problem behavior was brought into conformity with community norms or the

more the range of acceptable behavior within the community could be broadened, the greater the probability the individual could function effectively without negative social labeling (Sarason, 1974; Sarbin, 1970; Scheff, 1966).

Advocacy and social change are not new to other discipline fields, yet community psychology did not see the development of advocacy roles until the 1960's following studies of a number of social power movements with national attention (Alinsky, 1972; Bredemeier, 1964; Duff & Hollingshead, 1968; Peabody, 1971; Rappaport, 1981). During this period the field of community mental health began to see consultants who assessed the environmental settings in which the problem behaviors occurred. Their advocacy has led to the development of numerous buffer systems within the natural communities; self help through bartenders and beauticians (Cowan, 1982), alternative educational systems (Graubard, 1979), alternative residential settings for institutionalized patients (Fairweather, 1972, 1979; Kiesler, 1982), support systems for the older adults (Lawton, 1981), alternative outpatient counseling programs (Pollard & Fair, 1982), alternative health care clinics for women (Gottlieb, 1980), and other settings (Sarason, 1972). These buffer systems provide a structure through which Rhodes' threat-recoil situation is diffused. They provide an acceptable structure through which our perceived or real psychosocial problems can be addressed rather than be removed from the community.

The empirical tests of the effects of these community interventions have shown that the prevailing reinforcement contingencies in those community settings have influenced the outcome. Dohrenwend (1978) found that the impact of social support buffers on problem behavior or levels of stress experienced by individuals of high risk groups was poorly predictable. The major problems in predicting effects have been related to the difficulty in identifying mediating variables and processes that occur with the individual-environmental interaction and the multiple and sometimes conflicting sets of reinforcement contingencies.

Consultation Interventions As Advocacy And Outreach

There is a wide range of advocacy and outreach interventions that have been utilized by consultants in community settings. These interventions come from the fields of community psychology, organizational development, industrial psychology, education, behavioral psychology, and general systems theory (Heller, et. al., 1984). Caplan (1970) has provided the community consultant four types of consultation interventions for use with individuals or groups and organizations. The Caplan model makes use of several intervention techniques for unlinking, support mechanisms, theme interference

reduction, and education. Argyris (1970) has identified three primary tasks for conducting effective interventions including methods of generating valid information, maintaining the autonomy of the recipient client system, and generating the internal commitment to change chosen by the client. Other intervention methods associated with organizational development have included team building, survey feedback, job design, structured simulations, and other collaborative and confrontation interventions. Heller (1984) has reviewed the most utilized interventions in community psychology including those of Caplan and organizational development interventionists as well as the interventions of behavioral consultants in community settings. Attempts at developing a taxonomic classification of consultation interventions have generally been limited within a set theory base or discipline. One exception has been Kurpius (1985) who has categorized consultation interventions by recipient client systems: individual, group, organization, and community, borrowing from multiple fields of theory and discipline.

The task for consultants involved with the necessity or opportunity for advocacy and outreach intervention activity with their client systems is to determine and utilize the most effective and acceptable intervention methods for their client systems. The consultant is therefore technically eclectic while not necessarily subscribing to the theory or discipline supporting those interventions. Perhaps equally important for the consultant is to utilize the "small win" strategy that has been effective for the large social change directed by Saul Alinsky for many minority power constituent groups and organizations and described by Weick (1984): "A small win is a concrete, complete, implemented outcome of moderate importance. By itself, one small win may seem unimportant. A series of wins at small but significant tasks, however, reveals a pattern that may attract allies, deter opponents, and lower resistance to subsequent proposals. Small wins are controllable opportunities that produce visible results" (p. 43).

Two cases of consultation advocacy and outreach have been selected to demonstrate both the necessity and the opportunity for the consultant to intervene in behalf of client systems who continue to be threats to their communities and to society. For one client system the threat and recoil situation is related to the absence of effective solutions and the extent of treatment and support systems resources required. For the other client system the threat and recoil system involves these same factors as well as a major conflict of values for most of the individuals in this client system.

Consultation As Advocacy: Case Application

One of nation's most serious social, psychological, and health concerns is the problem of the Acquired Immune Deficiency Syndrome (AIDS). It is the first pandemic in recent history that has

been addressed largely by community groups and some state governments, while national leadership and experts continue to develop plans. The problem of AIDS has followed the threat-recoil situation that happens when the concerned individuals, that is, vulnerable-at risk groups, have values that are very much in conflict with community and societal normative behavior. All but a small minority of AIDS affected individuals are homosexual and/or intravenous drug users, the small minority are primarily individuals who have contracted AIDS through blood transfusions. The problem of how to respond to the serious problem of AIDS is, therefore, compounded by the social and psychological behaviors of both the homosexual and drug abusing groups.

One of the consultation intervention methods used in threat-recoil situations is to develop buffer programs and services to reduce the threat and to avoid the use of exclusionary measures. In communities where the affected individuals already have in place alternative services and support systems for addressing their homosexuality and drug abuse concerns, there has been more success with advocacy for addressing their AIDS concerns. In San Francisco there are now specialty outpatient and inpatient services for AIDS as well as support groups, special mental health programs, home care services, and specialty hospice facilities. In contrast, the advocacy efforts of the U.S. Surgeon General C. Everett Koop and others with the Texas Legislature resulted in the "House of Representatives overwhelmingly voting down the request [for funds for AIDS services and education] on grounds that the people suffering from AIDS in this state [most homosexuals and intravenous drug users] are breaking the law and therefore taxpayers' money should not be spent to do anything for them" (Randall & Hines, 1987, p. 36). Given the absence of federal direction and near insurmountable resistance in most communities it has been necessary for consultants to design small wins including the identification of key community leaders and health care providers who are less resistant, the development of interfaces with those community health, social, and support systems that should or could be involved in addressing the problems, and establishing an ad-hoc, temporary, community task force for developing alternatives for addressing the problems. In order to reduce the threat and resistance prevailing in some communities the focus of attention has been shifted to the families of the affected individuals and the problems they encounter in the course, generally two years, of this terminal disorder.

The task of behavioral management of the affected individuals and those health, mental health, and social service providers is more than a challenge. Some health care institutions, physicians, dentists, and other providers have fears that if their clientele were aware there were AIDS patients under their care, their clientele would go to other health care providers. The fear of losing their major extrinsic reinforcer, professional income, increases the resistance. In this situation the use

of ad-hoc community groups or commissions to develop alternative consortia of care has been found to be an effective method for advocating a means for the community to begin addressing the concerns about a serious community problem. Members of the community, then, have an integral role in the development of the alternative service, programs, and support systems for the affected individuals and their families. The affected individuals' behavior will be more congruent with the expectations for the special alternative settings which they would be utilizing, thereby reducing the pressure on the normative services currently available and resistant.

Complex social, psychological, and health problems such as AIDS will necessarily involve more than local community concern. Advocacy will eventually be conducted at state and national levels. Most of the state departments and boards of health have begun to address the problem of AIDS at least through reporting guidelines for their divisions of chronic and communicable disease control. Issues of funding for treatment are yet to be determined, for at this time, the federal and state Medicaid and Medicare funds have recoiled. Individuals over 65 with AIDS may qualify for Medicare if they have been disabled for two years under Medicare guidelines. Of course, this terminal disorder rarely has lasted two years. Medicaid eligible individuals with AIDS may qualify for services in extended care facilities, yet most states do not permit nursing homes to admit infectious disease cases. Important to understanding the reimbursement problems are the differences in conceptualizing the AIDS disorder. In reaction to the resistance of society, health care providers, and legislative bodies, the AIDS disorder has been conceptualized as a social psychological problem rather than as a traditional health care problem that is disease- or disorder-centered.

Consultation As Outreach: Case Application

Most communities have concern about their older adults and the growing difficulties they have related to increased physical limitations, chronic and major health disorders, social isolation, decreased income, and loss of significant social supports. Three million of the nation's older adults have a disorder known as primary degenerative dementia, or Alzheimer's Disease. One out of six older adults with Alzheimer's Disease have been admitted to nursing homes, they occupy 60 percent of the longterm care beds. Consultants from multiple health, mental health, social welfare, and legal institutions have been involved in both advocacy and outreach for these individuals and their families. Because of the large number of older adults with Alzheimer's Disease and the \$17 billion expended annually, advocacy and social policy changes have slowly occurred. Although the needs are great for those older adults who have been admitted for care in nursing homes, hospitals, and institutions, the major difficulties for families and

communities have been with the five out of six Alzheimer's older adults who continue to reside in the community alone or with their families. As their language and cognition skills decompensate, personal self-care requires assistance, and physical and social isolation prevail, the home care and outreach needs of these older adults and their families have become paramount. Consultants in the field of aging have necessarily faced issues of developing interventions that involve innovations for addressing the outreach needs of older adults.

Consultants in gerontology have found the use of ad-hoc community groups to be effective for generating outreach interventions for older adults. One such community group has formed a consortium with a community hospital, a community mental health center, and a university related center on aging and aged. Out of that consortium which includes not only service providers and experts but older adults as well, an in-home respite care is being developed. This outreach intervention will provide both care for the older adult as well as relief time for the family member usually responsible for the care. The same group has also been able to expand transit services in the rural areas to transport older adults who are still in the early stages of Alzheimer's Disease to community health, mental health, and social services and programs. This outreach intervention addresses the problems of decreasing physical mobility and of social isolation. In the case of older adults with Alzheimer's Disease the issues for the consultant are related more to the fiscal resources of the community, families, and service agencies than to resistances toward this high risk group of older adults. Further, there is a problem conceptualizing Alzheimer's Disease. Historically, society and the health care community have looked at the symptoms of this disorder as being a natural part of growing old in which some "senility" has been expected. At most it has been expected that older adult would require more and more health care. With better diagnostic capabilities service providers, families, and communities have become more aware of the importance of mental health and social support interventions.

Alternative services and support systems are also required for older adults with Alzheimer's Disease. Day programs of other older adult services and programs generally cannot handle the cognitive dysfunction of these individuals. Consultants working with community groups will need to advocate for specialty programs which would be designed to handle the problems of these Alzheimer's patients. In these specialty programs their cognitive dysfunction would be anticipated and therefore not a threat to the program activities that service providers and volunteers might attempt to carry out at any particular time.

Similar to many other complex health and social conditions the consultant will find that the health care reimbursement programs are more oriented toward acute care, reversible disorders, and illness that are episodic, and that little attention has been given to interventions

where the purpose is one of maintenance, slowing down the pace of the decline, or minimizing the residual effects of irreversible disorders. Generally, Medicare and Medicaid have ruled against reimbursement of psychiatric care for the Alzheimer's patient because there is no available treatment of choice for rehabilitation of the afflicted individual. Again, advocacy will be required to expand the conceptualization of the Alzheimer's disorder and to be able to develop outreach and support systems for this population of older adults.

Summary

Practitioners in human service delivery systems cannot help but find themselves in problem solving situations requiring decisions about advocacy and outreach in behalf of their service constituents. This is, of course, not unique to human services and community settings, but common to consultants in most fields involving human behavior. As the practice of mental health consultation has developed over the past three decades, the conceptual and theoretical bases have been generated for advocacy and outreach interventions on the part of the consultant.

In community consultation situations where the problems are complex, values are in serious conflict, resources are severely limited, and/or the solution alternatives are not known, the consultant should expect a threat-recoil interaction among the affected consultee parties. Advocacy and outreach interventions which enhance current buffering systems or which facilitate the development of new buffering systems in the form of specialty services and programs, have been found to be effective in these situations. To be sure, some consultants will question whether they should be involved in advocacy or outreach interventions. Generally, the opportunities for engaging in these interventions do not begin *de novo*; the consultant is more likely compelled to address the efforts already going on within the community or organization. Carkhuff, who is well renowned in both counseling and consultation education has described very well the consultant's situation in developing an intervention: "An intervention is both a response and an initiative. It is a response to a situation that defines a need. It is a response to a deficit or to what is not present. At the same time, it is an initiative to influence that situation—to fill in what is not present, to transform the deficits into assets. In short, an intervention is an attempt to make a difference" (Carkhuff, 1983, p. 163).

References

- Alinsky, S.D. *Rules for Radicals*. New York: Vintage, 1972.
- Argyris, C. *Intervention Theory and Method*. Reading, MA: Addison-Wesley, 1970.

- Bredemeier, G.C. The socially handicapped and the agencies: A market analysis. In F. Riessman, J. Cohen, & A. Pearl (Eds.), *The Mental Health of the Poor*. New York: Free Press, 1964.
- Briscoe, R.V., Hoffman, D.B., & Bailey, J.S. Behavioral community psychology: Training a community board to problem solve. *Journal of Applied Behavior Analysis*, 1975, 8, 157-168.
- Caplan, G. *The Theory and Practice of Mental Health Consultation*. New York: Basic Books, 1970.
- Carkhuff, R.R. *Sources of Human Productivity*. Amherst, MA: Human Resources Development, 1983.
- Cowen, E.L. Help is where you find it: Four informal helping groups. *American Psychologist*, 1982, 37, 385-395.
- Dohrenwend, B.S. Social stress and community psychology. *American Journal of Community Psychology*, 1978, 6, 1-14.
- Duff, R. & Hollingshead, A. *Sickness and Society*. New York: Harper & Row, 1968.
- Eisenberg, L. An evaluation of psychiatric consultation service for a public agency. *American Journal of Public Health*, 1958, 48, 742-749.
- Fairweather, G.W. *Social Change: The Challenge to Survival*. Morristown, NJ: General Learning Press, 1972.
- Fairweather, G.W. Experimental development and dissemination of an alternative to psychiatric hospitalization: Scientific methods for social change. In R. Munoz, L. Snowden, & J. Kelly (Eds.), *Social and Psychological Research in Community Settings*. San Francisco: Jossey-Bass, 1979.
- Fox, R.M. & Schaeffer, M.H. A company-based lottery to reduce the personal driving of employees. *Journal of Applied Behavior Analysis*, 1985, 14, 273-285.
- Friedlander, F., Brown, L.D. Organization development. *Annual Review of Psychology*, 1974, 25, 313-341.
- Gibson, G. Models of community mental health consultation. In D.J. Kurpius and W. Lanning (Eds.), *Psychoeducational Consultation: Conference Proceedings*. Bloomington, IN: Indiana University, 1976.
- Gottlieb, N. (Ed.) *Alternative Social Services for Women*. New York: Columbia University Press, 1980.
- Graubard, A. From free schools to "educational alternatives." In J. Case & R. Taylor (Eds.), *Co-ops, Communes and Collectives*. New York: Pantheon Books, 1979.
- Heller, K., Price, R.H., Reinhartz, S., Riger, S., Wandersman, A., & D'Aunno, T.A. *Psychology and Community Change: Challenges of the Future*. Chicago: Dorsey Press, 1984.
- Holland, J.G. Behaviorism: Part of the problem or part of the solution? *Journal of Applied Behavior Analysis*, 1978, 11, 163-174.
- Kiesler, C.A. Mental hospitals and alternative care: Non-institutionalization as potential public policy for mental patients. *American Psychologist*, 1982, 37, 349-360.
- Krasner, L. (Ed.) *Environmental Design and Human Behavior: A Psychology of the Individual in Society*. New York: Pergamon Press, 1980.

- Kurpius, D.J. Consultation interventions: Successes, failures, and proposals. *Counseling Psychologist*, 1985, 368-389.
- Kurpius, D.J. OD: A theory and process for influencing human and organization development. *Improving Human Performance Quarterly*, 1979, 8, 217-226.
- Lawton, M.P. Community supports for the aged. *Journal of Social Issues*, 1981, 37, 102-115.
- Mannino, F.V., MacLennan, B.W., & Shore, M.F. *The Practice of Mental Health Consultation*. New York: Gardner Press, 1975.
- Nietzel, M.T., Wiatt, R.A., MacDonald, M.L., & Davidson, W.S. *Behavioral Approaches to Community Psychology*. New York: Pergamon Press, 1977.
- Peabody, G.L., Power, Alinsky, and other thoughts. In H.A. Hornstein, B.B. Bunker, W.W. Burke, M. Gindes, & R.J. Lewicki (Eds.), *Social Intervention: A Behavioral Science Approach*. New York: Free Press, 1971.
- Pollard, C. & Fair, S. Community psychology and the alternative counseling center: Indications for future rapprochement. *Journal of Community Psychology*, 1982, 48-53.
- Price, R.H. The taxonomic classification of behaviors and situations and the problem of behavior environment congruence. *Human Relations*, 1974, 27, 567-585.
- Randal, J. & Hines, W. Local communities take the lead in coping with AIDS. *Governing: Congressional Quarterly*, 1987, 1, 34-40.
- Rappaport, J. In praise of paradox: A social policy of empowerment over prevention. *American Journal of Community Psychology*, 1981, 9, 1-26.
- Rhodes, W.C. *Behavioral Threat and Community Response: A Community Psychology Inquiry*. New York: Behavioral Publications, 1972.
- Sarason, S.B. *The Creation of Settings and the Future Societies*. San Francisco: Jossey-Bass, 1972.
- Sarason, S.B. *The Psychological Sense of Community: Prospects for a Community Psychology*. San Francisco: Jossey-Bass, 1974.
- Sarbin, T.R. A role theory perspective for community psychology: The structure of social identity. In D. Adelson & B.L. Kalis (Eds.) *Community Psychology and Mental Health: Perspectives and Challenges*. Scranton, PA: Chandler, 1970.
- Scheff, T.J. *Being Mentally Ill: A Sociological Theory*. Chicago: Aldine, 1966.
- Tharp, R.G., & Wetzel, R.I. *Behavioral modification in the Natural Environment*. New York: Academic Press, 1969.
- Wicker, A.W. Processes which mediate behavior-environment congruence. *Behavioral Science*, 1972, 17, 265-277.
- Weick, K.E. Redefining the scale of social problems. *American Psychologist*, 1984, 39, 40-49.

Chapter Five

Advocacy And Outreach: Applications to College University Counseling Centers

David J. Drum, & Luis F. Valdes

Reaching Out

In deed and in theory the role of the college counseling service has changed dramatically in the last 20 years. Gone are the days when the counselor sat passively waiting—waiting for people to recognize their need for help; waiting for them to seek out that help; and waiting for them to attain it through long-term individual counseling. This does not mean that individual counseling is no longer highly prized and sought out by students, for it is. Individual counseling continues to provide a necessary lifeline to those in need, but today it is no longer considered enough for several reasons.

- Students usually wait a long time after they are troubled before seeking help and thus undergo needless mental turmoil.

- Students' increasing cultural, economic, and political diversity makes them less aware and receptive of the traditional helping services.

- Traditional services do little if anything to help anticipate and prevent problems and this "waiting till the horse is stolen to lock the barn" approach is no more acceptable in today's mental health field than it is in the field of physical health.

- Traditional services concentrate on repair and remedy and offer little support and growth opportunities to those at critical life crossroads — susceptible to but not yet victim to developmental demands they are unprepared to handle.

- Finally, not all problems can be repaired intrapsychically. Sometimes external barriers must be removed; institutional policies changes or other environmental forces dealt with before healing can begin. Traditional services address none of these issues.

Now college counseling services do considerably more than sit and wait. Today the provision of traditional one-to-one counseling services accounts for just over half the time and energy output of a typical college counseling center. What about the rest of that time and energy? It is spent in the provision of outreach services aimed at providing developmental support and anticipating problems students might face so that those potential problems can be avoided. Two key methods of providing these critical types of assistance are consultation and advocacy, the focus of this handbook.

Our Definitions

Confusion exists about the distinctions among the terms outreach, advocacy, and consultation—largely due to the fact that so many people often use them interchangeably. Therefore, we will first make clear our conceptualization of the terms so that readers can more easily follow our thoughts and experiences concerning the services they represent.

Outreach This we use as the global term for all services that are not the more traditional group or one-to-one counseling. Outreach by college counseling services began as an alternative to traditional services so that far more students could benefit from the knowledge and skill of the counselor in a more timely and valuable fashion. Traditional methods were seen as serving the few—the relatively privileged middle-to-upper-class student of the majority culture. Traditional methods were those of the private medical practitioner—appointment, office visit, diagnostic testing, case conferencing, verbal treatment—and the treatment was largely limited to intrapsychic restructuring (not cultural, systemic, organizational or legislative change) provided at times far distant from the origination of the need for assistance, and often only after the client had become significantly dysfunctional.

Outreach was an attempt to change all that. Its proponents said that traditional services, while valuable and necessary, were not enough. They wanted counseling services to diversify, to go beyond the limitations inherent in reliance to intrapsychic change, to expand the number of available helpers by using helping professionals of various natures and backgrounds, to leave the office and the counseling centers, and—simply yet profoundly—to reach out.

Advocacy and consultation we define as two important methods of providing outreach services. In practice, advocacy and consultation are often intertwined, the distinctions between them blur so frequently that the interchangeable use of the terms is understandable—but not helpful to a careful examination of the services—so we will make the following distinctions between consultation and advocacy.

Consultation Consulting as defined by Webster's dictionary is the process of providing professional or expert advice; therefore, a consultant is an advisor with special expertise who is sought out by another for collaborative assistance. Unfortunately for our purposes, this definition could just as easily be applied to a counselor—who is an expert in psychology providing advice to clients who seek it. In order to distinguish between our counseling and consulting roles, our counseling center has redefined the term "consulting" to mean those services provided to agencies, programs or institutions.

Counselors become consultants when they provide expert advice to an organizational entity, offering the individuals within it the means to assess, understand, and solve difficult dilemmas or problems of the organization. This may or may not require that they address personal and interpersonal difficulties among the individuals within that organization. Should such difficulties be addressed, the consultant deals with them as they apply to and affect the organization. For example: Consultants, discovering a key member of the organization has a cocaine problem, do not enter into treatment of that individual's substance abuse as would a counselor; instead, they assess and identify the impact of the individual's problem on the organization and recommend and sometimes facilitate methods of dealing with it. This may range from referring the individual to counseling and a chemical dependency program to launching an organization-wide drug education campaign, or both. It does not include personal counseling of the individual except as required by the organization's needs; it does not include intervention in the area of that one individual's substance abuse, except for referral.

The consultant is the third party, often the outsider working with the organization and its members in a limited often contractual situation. The consultant can inform, recommend, assess, support, and evaluate the organization, only the organization through its members decides if, how and when to change. Consultants are not responsible for the long-term implementation of their recommendations, neither do they treat individuals directly, only indirectly through the organization.

Advocacy Webster's dictionary tells us advocacy is the act or process of advocating or supporting and that an advocate is one who pleads the cause of another. Once more, that's not enough for our purpose. Gallessich in *The Profession and Practice of Consultation* (Jossey-Bass, 1982) recognizes our difficulty. "The consultant role and the role of advocate are often confused, but their goals and boundaries are different." She describes consultants as working within the agency goals of their clients, and then she goes on to say: "Advocates, in contrast, are committed not only to advise their clients (individuals, groups, or organizations) but also implement adversarial actions in the clients' behalf." (Emphasis added.)

Counselors become advocates when they join their client in supporting or advocating change from a third party. Advocates may

act in concert with the client or they may act alone, but in behalf of the client. The advocate's client may be an individual, organization or special population group.

The advocate seeks change and prevention and remedy for others from others, usually others not his clients. They, more than counselors and far more than typical consultants, enter into the area of values and judgement called for by their decision to advocate a specific change. The advocate chooses to support the cause of one individual or group over that of another. Advocates elect to deal with outside forces in order to bring about or make possible the healing and/or healthy development of their clients.

In this spirit, our counseling service defines advocacy as the process of supporting and/or pleading student causes that increase their dominion over outside negative influences on their development and the quality of their lives. This redefinition recognizes that we both plead for and plead with our clients. We plead for them when we petition administrators to eliminate external barriers like discriminatory rules or policies, or legislators to fund adequate and humane institutional services; we plead with them when we urge and counsel them to move toward personal empowerment by overcoming those barriers and forces that would inhibit them—and sometimes join them by active participation in the process of environmental change.

Today's Outreach

In essence, the outreach consciousness of the 60's not only called for an expansion of helping methods but also for a clearer understanding of what methods should be used, for what purposes, and at what times. Important questions about the timing of service relative to the need for help began to surface. Those concerned about the lateness and limitations of traditional interventions began to talk seriously about prevention and earlier intervention and *postvention*—intervention immediately following a crisis for the purpose of restoring a healthy stability.

Once timing was questioned so was target. Why should we limit help to individual counseling and an occasional workshop or group? What about the needs of groups and organizations that make up so large a part of so many people's lives? Isn't it possible that laws, societal forces, the entire environment may act to perpetuate the problems of individual? This barrage of questions and the expanded consciousness they represent continues to evolve today.

Twenty years later, most of the goals of the outreach movement are being achieved. Help is being provided to a far wider range of clients and client needs, with a greater variety of helping methods, and for more varied purposes—to prevent, to support development, to remediate. Current methodology and techniques allow helping agents to be of assistance at more levels of client need than ever before. With the above distinction of terms in mind we can now explore and

compare the parts advocacy and consultation play in outreach services by looking not at the dictionary but at our clients and their needs.

The Levels of Need

Today our options have so increased that we sometimes need help sorting them out! To illustrate and clarify all that is possible to the college counseling service, a schematic of the levels of need for assistance and the means of meeting those needs has been developed (Drum, 1987). We include it here to illustrate our discussion. (See Figure 1.)

Figure 1

SEVEN LEVELS OF NEED		
LEVEL	DESCRIPTION	INTERVENTION TYPE
1	No Existing Need, Possible Susceptibility	PREVENTATIVE
2	No Known Need Probable Susceptibility	
3	Emerging Need or Challenge	DEVELOPMENTAL
4	Clearly Existing Need or Challenge	
5	Deteriorating Unmet Need— Emerging Crisis	
6	Recurring Crises or Problems	PSYCHOTHERAPEUTIC
7	Entrenched Dysfunctional Life Patterns	

Each level of need can be seen as particularly responsive to and demanding of different types of intervention of varying method and purpose. In this scale interventions are broadly categorized as Preventive, Developmental or Psychotherapeutic, with each category identified as primarily applicable to certain levels of need. By examining the characteristics of each level we begin to see how and when and why particular methods of intervening can be more effectual than others.

Level 1 Need The first and lowest level of consumer need for assistance applies to those who have no existing problem yet might be susceptible to one should preventive measures not be taken. Newly matriculated freshmen, for example, may choose their class schedule for the fall semester unaware of the increased risk of physical assault or harassment associated with night courses, or courses in certain campus locations.

The counselor has a number of intervention options at this level of need. A passive stance is to wait—ready to treat those students who, unaware, sign up for night courses, encounter difficulties and subsequent anxiety, and come for help. Or an intervention could be constructed that informed students before registration of the risks involved. Or the counselor could decide to advocate for all students by attempting to change institution policy that allowed evening coursework or to advocate that additional lighting and police protection be provided in areas known to be high risk locations.

Level 2 Need The need for assistance is greater—although there still exists no recognizable problem—because the susceptibility to difficulty has increased from possible to probably. Using our previous example, the difference between need in levels 1 and 2 is the difference between the freshman class in general before they choose classes and those freshmen who have registered for classes in high risk situations and no longer have the option of changing their schedules. Level 2 intervention options are similar to level 1 except that they are provided to those at greater risk whose motivation, consequently, is generally higher.

Let's apply the options of advocacy and consultation to these levels of need. A counselor who believed that some students are at great risk of becoming alcoholic during the college years, who saw a direct correlation between teenage drinking on campus and date rape, and who was convinced that most student-based vehicular accidents resulted from excessive drinking, might decide to petition the college administration or the state legislature for adoption of a policy that prohibits consumption of alcoholic beverages at all college social events, in college residence halls, and by all students under 21 years of age.

The counselor also has a consultative option, such as designing workshops on alcohol and drug use and abuse specifically for

fraternities. Such an intervention might be crafted to focus on the organizations' leaders; it might illustrate to them the connections between overdrinking and hazing; it might teach them how they can achieve unity and brotherhood without encouraging overdrinking—or hazing. Should a fraternity already acknowledge their problem, the counselor turned consultant might offer them an intervention designed to assess the organizational and personal factors that contribute to the problem.

Regardless of whether the level 1 or 2 intervention is advocacy-based, consultative or of some other form, its primary purpose is to prevent, since each intervention at these levels seeks to eliminate possible or probable problems before they emerge. By definition, preventive interventions require the intervenor's advocacy—either for or with the individual or group needing help—advocating for, as in the case of changing institutional policy on consumption of alcoholic beverages, advocating with, as in the development and presentation of the consciousness raising workshop for fraternities. Preventive interventions also call on the consulting skills of the counselor who works with the groups, agencies or organizations that may be contributing, directly or indirectly, to an individual's problem.

Level 3 Need At this level prevention is no longer possible, for the need has begun to emerge as a dilemma, challenge or problem. On the individual level, this might be a student who wants friends at school but is uncertain how to proceed and can't understand why no friendships have developed naturally. Since the need for friends is relatively new and has not yet caused any disruption or difficulties, at this point this person's motivation is only minimal to moderate.

Here as in the first two levels, the counselor has options ranging from the traditional passive approach of waiting until the need generates enough discomfort or dysfunction to drive the individual to seek help, to the more active assertive methods that include advocacy and consultation.

The advocate for better interpersonal relationships in the first year of college can sensitize residence hall or student affairs staff to the predictable percentage of students who will need help with friendship-building skills. The consultant, called in by the new Director of Housing, can conduct environmental assessments of residence halls and their community lifestyles to determine what if any obstacles to friendship-building exist. Either advocate or consultant might offer specific training modules to the staff that enable them to better foster relationship skills among the residents.

Level 4 Need The emerging need described above has gone unmet and now becomes more pressing. It becomes a clearly existing need and the consequences of not resolving it are now evident to the group or individual. The difficulties, irritations, and frustrations the problem generates are difficult to ignore.

In the case of the student who wanted friends but had not been able to develop friendships, the failure to do so is now producing a sense of aloneness, perhaps loneliness and feelings of inadequacy. Intervention at this point is more complex, not only the primary problem but also the disturbances it has spawned must now be addressed if the person's development and growth are to be put back on track.

Level 5 Need By now the unmet need has begun to affect the client's quality of life, whether the client be an individual or group or organization. What was once only a possibility (level 1) became a probability (level 2) and then an emerging need (level 3) that remained unmet for some time and deepened in intensity (level 4) and that has now become a serious life problem, perhaps with an emerging crisis (level 5).

The client's confusion about how to resolve the problem increases, and, at the same time, so does the urgency to resolve it. Our friendless student now begins to feel desperate and rejected. He is certain something is fundamentally wrong with him—or the institution, or both. He feels compelled to take action—any action—if only he knew what to do.

Preventive interventions are no longer feasible; for there is no question at all that the problem exists and is becoming entrenched. What is usually needed and wanted is direct, assertive action. And it is wanted and needed now.

Because of this urgency, advocacy aimed at changing the environmental conditions that contributed to this person's isolation may help others but is seldom adequate for this individual. His needs have increased to the point that the counselor's options narrow to individual counseling and group therapy.

Levels 3, 4, and 5 are categorized as primarily met by developmental services, since the needs or problems being addressed arise from everyday developmental challenges, such as the need to develop new interpersonal skills, to complete life transitions (school to work, spouse to parent, and so on), or the need to develop greater mastery of oneself. By definition developmental services are designed to provide assistance closer in time to the origination of the need or problem than are psychotherapeutic services, but not before the problem exists as do preventive services.

Who was it who said "Timing is all"? Certainly it applies to the choice of intervention method. The earlier one intervenes in relationship to the problem's origin, the more numerous the opportunities for advocacy and consultation forms of developmental services. The later the intervention the more one must rely on labor intensive, direct, remedial methods of assistance.

Level 6 Need When a problem has reached level 6, the individual, group or organization is usually motivated to seek out a solution because the ability to function has been seriously undermined. At this

level, clients experience intermittent and development and threaten survival. Intervention can no longer be focused on a localized, single issue, because—regardless of origin—there are now multiple needs and problems to be resolved if stability is to be restored.

Level 7 Need At this the highest level of need, the problems, deficits, and conflicts have existed so long unresolved that extensive remedial and reconstructive help is necessary. Whether provided through individual or group therapy or organizational consultation, it will be a long-term process.

Interventions at level 6 and 7 are labelled remedial because they seek to remedy severe, ingrained dysfunction. The primary methods at these levels are individual or group psychotherapy or intensive long-term organizations consultation. Preventive or developmental assistance is no longer sufficient. Clients at these levels of need must have extensive help if they are to reestablish dominion over their lives or organizations.

Imagine, for example, that the Director of Student Activities came to you, the college counselor, for help with a fraternity that has been in serious decline for three years. During this period it has developed high internal strife and a reputation for hazing and excessive drinking. Four years ago none of this existed. The newly installed leaders, recognizing their serious, perhaps uncontrollable, situation, and fearing they will be kicked out of the interfraternity council (where they are already on a second term of probation), have requested help from the Office of Student Activities.

Because of the time that has lapsed since the problem began, because the fraternity is now going from one crisis to another, because you are sought out for services, this intervention can be described as consultation services at a level 6 need. Such help is likely to begin with a careful analysis of the nature, strength, and intensity of the problems as well as the organization's resources and resolve available to deal with them. The assessment will probably reveal, as most do, that the problems are not a magic beanstalk; they did not spring up over night. Instead, the organizational climate has shifted over time and in critical ways provided fertile soil for problems. Sadly, these assessments frequently pinpoint a time when action could have prevented the problems that must now be treated at levels 6 or 7.

The fraternity in trouble, for example, may learn that five years ago there was an emerging need (level 3) for strong leadership that was not filed, and that, with only weak leaders, competitive cliques formed and began the self-destructive practices that exist today. The assessment might reveal how this unattended organizational development led to a gradual disintegration of the entire leadership structure as well as the brotherhood the fraternity professed to support and promote. This organizational decline then resulted in some members taking pledges on humiliating and dangerous hazing expeditions just to irritate the clique that disapproved of hazing.

Had the leaders of this organization waited a few more years to seek help the problem would have reached level 7 or past—into "meltdown." Entrenched dysfunction, with its resultant self-destructive organizational behavior patterns, might have convinced members their problems were insurmountable and convinced them to dissolve the organization.

Summary

It has been nearly 25 years since we first began to think that alternative methods of treatment could be developed. As the seven level scale of consumer need for assistance illustrates, we now have available at least seven points of potential intervention and the necessary methodology and techniques to implement assistance tailored to the client's need. A quarter century ago we had, basically, only two. Refinements in intervention approaches have enabled us to intervene in ways barely conceivable in the past.

Now we help people we never meet through preventive services of all kind, through carefully crafted self-help services (telephone tapes, computer software programs, educational brochures and self-assessment instruments). Newer methods have developed a problem focus that enables us to offer theme groups and workshops helpful to many people who share a common need—whether assertiveness training, resolving dysfunctional jealousy, or overcoming rejection experiences without unduly restricting our living and loving. Now we can make the organization our client and apply new understanding and methods to the development or repair of organizational climates. We now view our institutions as possible contributors to unhealthy or insufficient growth and plead with our administrators, legislators, or communities to change rules and policies and stereotypes that encourage or force dysfunctional development on special populations. And, of course, we should and often do treat the individual in a traditional counseling setting.

Through a greater awareness of the different levels of need, motivation toward change, and depth of intervention, as provided in schematics like the seven level model given here, we can time and tailor our interventions more strategically. We can construct multiple or layered interventions and sequence them to provide more effective help to those with particularly difficult problems. The view of need for assistance as a continuum can help us see our methods as both sufficient help for some and preliminary help for others. We can use the different methods and levels of intervention to ease and encourage the client toward that level best suited to lasting resolution of his or her problem.

Through the preventive services of educational campaigns, for example, we can not only help prevent a problem, but also alert people who already have the problem that more help exists and where they can find it. With stand-alone developmental interventions that are

private and safe (a brochure, computer program, or telephone tape, for instance) we can reach for the first time the person already suffering from a deficit but still unready to admit it. With short workshops we can lead those who need more help to theme groups, psychotherapy groups, or long-term one-on-one remedial counseling. With counseling we can help those who want to help themselves, with organizational consultation we can help floundering or inefficient agencies, with advocacy we can even help those who won't or can't help themselves. But to do all this, we must go beyond the traditional, we must reach out in creative and proactive ways.

We share with you now some of the ways and means we have used to do that.

The Outreach Model

The authors believe definitions and ideas and theories are not enough to create a program, much less an effective and responsive counseling center. Definitions, ideas, and theories must be applied and used, evaluated and changed, before we can claim them as an integral part of our services. This section, then, describes some of the outreach activities of the Counseling and Mental Health Center at the University of Texas at Austin, particularly those that have involved various kinds of advocacy and consultation.

Just as in individual counseling, there is a process for conducting successful outreach activities, be they advocacy actions, consultation programs, or developmental interventions. The model we use is based on modifications of environmental change technology (Conyne & Clack, 1981) and allows us to proceed smoothly through any outreach request and intervention, paying particular attention to the advocacy needs of the client. We have identified eleven steps in the process.

The Outreach Process

- 1) Pre-entry issues
- 2) Initial response to request
- 3) Agreement to explore or initial contact and entry
- 4) Contracting
- 5) Exploration/information gathering
- 6) Case conceptualization
- 7) Formulation of intervention
- 8) Implementation of intervention
- 9) Evaluation
- 10) Follow-up
- 11) Termination

Pre-entry Issues and Beyond

The *pre-entry issues* are basic and essential, they refer to the mission and philosophy of the counseling service, as well as to that of administration and staff, and they will of course predetermine

direction and commitment to outreach services in general or advocacy and consultative services in particular. Effective outreach services require an agency committed to early intervention. Both administration and staff must be committed to initiating, maintaining, and/or developing expertise in all areas of outreach. They must see and seize the opportunity to serve large numbers of clients, to expand their impact on the university campus and to increase the visibility of that impact (Lerman, 1983). Before any type of outreach activities can be effectively implemented, an agency-wide commitment must be made.

It is not enough to state a vague or broad commitment, the commitment itself must be explored, understood, and refined so that the agency staff assesses and acts on each request or opportunity for intervention from some basic tenets and guidelines. To change or expand an agency's service delivery commitment requires reassessment and thoughtful consideration of resources and goals. Whether assessing your existing commitment or considering a new commitment, there are important questions to ask about your agency and its personnel.

If you were concerned with adding advocacy services, for example, some of the questions might be: What are the individual and collective professional goals, values, and needs of the staff? What are the agency needs? Do you have an accurate assessment of your agency's advocacy skills? Have you scanned the campus for opportunities to advocate? Have you assessed your past and present outreach requests? Could those requests have been better handled through advocacy? What could have been advocated? How? Why? Have you made a thorough assessment of past successes and failures in the informal but inevitable advocacy activities that occur in every counseling service? Can you describe the overall direction of your general outreach activities? Is advocacy consistent with that direction? Do you regularly provide the campus with information about your counseling center's outreach program? Does the information include advocacy? Are you currently educating potential clients about your advocacy program through other outreach activities?

The last question is an important one, for the interdependence of services and service requests is nowhere more apparent than in outreach activities. One program leads to another, one type of service uncovers the need or desire for another type. We referred earlier to seven levels of need and the types of services available to meet them. Outreach activities are crucial to meeting those needs sooner and better, whether through prevention, developmental enhancement, or remediation. The individual types of outreach services, we think, should not be so compartmentalized that we lose sight of the whole continuum of need and the whole ranges of services available for those needs. We learned this lesson through our Women as Winners program.

Everybody Wins

One response a counseling center can provide to developmental tasks encountered by college students is systematically designing, sponsoring, and implementing on-going preventative outreach programming. One such effort on our campus involved the development of a week-long series of panels, lectures, radio and television shows, films, and workshops. Each year the series revolves around a general, comprehensive issue. Each day of the program focuses on a particular sub-issue or theme, and each individual program event emphasizes a particular aspect of the sub-issue. Each event is also designed to include particular approaches within the structured activities that provide information, examine current research and theory about the topic in question, increase participants' awareness of their individual emotional, cognitive, behavioral and physical development, and address the socio-political factors relevant to the topic.

"Women as Winners" was one of those series, developed over 4 years ago, and it continues to have an agency-wide effect on our service delivery decisions. The response to that series and the data gathered from its participants were major factors in our decision to develop programming for women, though not the only factors we considered. Our final decision—that we develop comprehensive, on-going, outreach programs for women—came from several sources.

Over the years, our clinical data had suggested that women, partially as a result of the women's movement, had begun to express particular concerns and come to the counseling center with an increasingly identifiable pattern of unresolved developmental tasks. Also, through staff development activities the clinical staff had maintained a solid familiarity with current theory and research in women's issues from which our programming activities were drawn. Finally, a majority of our previous outreach program participants, whatever the topic, had been women. Through a formal and informal evaluation of past programming it was decided that more specific women's programming was needed. Our data provided us with information about which specific program topics were most frequently requested.

But the changes did not stop here. Once outreach programs became more numerous, our consultation requests from women-oriented groups increased. As our staff became more familiar with local issues their recognition of the need for advocacy and their expertise in providing it increased. From that original one-week series has come a standing Women's Concerns Committee for the purpose of program development at all levels of need and all types of services.

Once an agency has defined and stated its commitment to outreach activities, there are endless avenues to providing those services. The effect of a theme-series is only one. Regardless of the means used to announce your commitment, and sometimes with no more effort than

word-of-mouth advertising that your agency is offering new services, it doesn't take long for the requests to begin—and suddenly you are at step 2 of the process.

Requests and Giving More Than You're Asked For

The request for services usually comes in the form of a telephone call: "Can you do a workshop on stress management (or any number of other well-known mental health topics) for us?" (Domke, Winkelploch, & Westafeld, 1980). Depending on the mood and demeanor of the client and/or the person who takes the request, depending on the particular time of the semester, the number of previous requests for this workshop that particular semester, the history of the client's or organization's previous request, depending on any combination of these and other factors, there are many ways in which this request could be handled. Ideally, however, no request is taken merely at face value.

Agencies experienced in outreach services typically investigate the request to determine the best way to help, rather than merely responding to the specific and limited request. Every service request should be handled thoughtfully. The *initial response to the request* should further explore the request in order to uncover real problems, real issues, and real opportunities for meaningful change. Any legitimate request for programming should be viewed as a request for change; that is, as a request for something in the system to be different.

So, then what is the appropriate way to respond to the request for change? For most requests, the recommended response is neither yes or no but more questions: How did you come to pick this strategy (program, workshop)? Has this topic been an issue for you before? Can you give me some examples of how this is an issue for your group? How did you handle it before? How well did that work? What didn't work? Why do you think it isn't working now? Who is interested in this program? Why now? What if this program didn't happen? What would you do then? What is it that you would like to have happen as a result of this program?

As you explore the request with the potential client, you will also be asking silent questions of yourself: How much pain or discomfort is the system or the target group in question feeling? How much responsibility are the system and sub-systems taking for the problem and for the solution? Is the system in too much trouble to be worked with effectively? Has the trouble been around for a long time? At this point, the system can be assessed in terms of the seven-point level of need scale and you begin to make preliminary decisions on the service best-suited to the caller's needs—which may or may not be what has been requested. As the problems of the group or the environmental system involved are discussed, the motivation of the group can be assessed, the real goals of the intervention become more tangible to

you and to the client, and the potential impact of the intervention can be determined. As the goals become clearer, it can be determined if it is best to provide a direct developmental service, consultation, or an advocacy-based form of assistance.

Contact!

You have tentatively decided that advocacy is a possibility with this client. What next? Should advocacy be employed, navigating through initial contact issues may be quite interesting—as well as treacherous. One of the first steps in the initial contact process is defining your advocate role. You must state clearly that your role potentially includes not only education or advice but also implementation of actions in the client's behalf. You may need to educate the client about the contrast between the various intervention roles of a therapist, educator, consultant, and advocate. Above all, it *must* be clear to both you and your client which roles are to be played by whom and when (Lippitt & Lippitt, 1978). This is particularly important if you have had a previous role other than advocate with this client.

Can the system tolerate an advocate for change? As you explore that question, you simultaneously explore the potential for working smoothly with your client. When one's role is to be advocate within a system, values become increasingly relevant, particularly in terms of values conflicts between parties. Before the advocacy roles is taken, one should assess one's welcome—by the client and by the system which is subject to the intervention—in order to assess whether advocacy is the answer.

Which Hat Do I Wear?

The hardest and most important aspect of the initial contact is deciding what role you will play. Fortunately, at this point you have considerable latitude. Another example of a particular consultative intervention with some advocacy activities helps illustrate the process of responding to an initial request, defining what role to take within an organization, gathering information, and then *changing* roles.

A student died, tragically and unnecessarily. It was determined that he died of alcohol intoxication, allegedly the result of hazing activities by members of a campus fraternity. A counseling center consultation team was called in by joint request of the university administration and the staff of the private residence hall where the victim had lived. Extensive information gathering began and it became clear that both the fraternity and the deceased's private, off-campus residence hall had been experiencing serious organizational, leadership, and management problems for a significant period of time.

The team contracted with the residence hall for intervention through a consultative relationship with the management and worked for some weeks in this capacity, still learning more about the situation. Eventually, as the team's understanding of the events leading up to the tragedy evolved, they began to see the need for

advocacy. They decided that change in the residence hall or even in the one fraternity involved was not enough.

At that point, the team chose to become advocates for changes in the management, rules, and regulations used not only by the residence hall and the fraternity, but also by the university. They eventually advocated for and facilitated change in university policies used by the administration to guide fraternity activities and their relationship with the fraternity.

Once you have made your initial response and begun to think in terms of agreement to work with this client, you can't decide on even a tentative role without some preliminary assessment of the problem.

The Diagnosis is . . .

Defining the problem is a crucial component of the early outreach assessment process; yet it too may evolve and change during the information gathering. Knowledge of the history of the problem and what has been tried to remedy the problem is a good starting point. Through this historical exploration, system barriers and supports (organizational structures, administrators, interest groups, other players, written policy and procedures statements, informal policy and procedures, and so on) can be identified and dealt with in effective ways. Additionally, one determines the resources available through this chronological study of the problem. A thorough assessment of the previous resource allotments and the decision-making behind those allotments will come later when you are planning strategy. What barriers were previously encountered? Do they still exist? What players or structures were supportive in the past? Do they still exist?

Whereas the Party of the First Part . . .

The outreach worker is an expert who assesses the situation from a vantage point different from those involved in it and you may soon see that the intervention required is different from the one requested. The intervenor and the people needing intervention must agree on the best form of help. The *contracting* step is, in reality, the agreement between the intervenor and the client to continue with the remaining steps in the process. Contracting can be conceptualized as a dynamic process along a timeline, as opposed to a single event (Ulschak, 1978). Educating the client about the process is an essential part of the contractual agreement. Fully informing the client and making clear all expectations of client and of intervenor, will prevent surprises and reduce the possibility of being "blind-sided."

Contracting involves the establishment of: 1) a clear statement of goals (both yours and the client's); 2) a clear statement of observable, tangible, concrete outcomes desired; 3) strategy statements about the activities, processes and mechanisms used to achieve those goals; 4) a process of identifying realistic resources available and "person-power" to use those resources (the what and the who, if you will); 5) limit-setting behaviors or the true commitment of time, energy, resources

(including money), and support systems which the advocate and the client have available to the project; 6) a realistic time frame to implement the strategies proposed; 7) a system of periodic checkups or milestones to monitor progress, and 8) ways to facilitate re-contracting (if needed) based on data from the periodic checkups

The Team Approach

It has been our experience that the use of a *change team* increases the probability of success of advocacy programs. The change team, as opposed to an individual change agent, increases significantly the ownership of the goals, the amount of participation in the planning and implementation of the strategies, and the potential for meaningful change; it also ensures the project sufficient support to reach the goals and decreases the potential for significant barriers that hinder, stall, or stop the project.

The change team should include individuals from, or at least a representative of, any particular group invested in the change being advocated. Each team member should be informed and involved in the development of the contracting process. Team building strategies should be utilized whenever possible to form an effective working advocacy group. If skills deficits that significantly affect the project exist, it is helpful to have the individuals on the change team make a commitment to provide or obtain skills training in the deficit areas.

For example, for the past 7 years the counseling center and the university housing office have been involved in a highly successful linkage program with residence hall staff that has required the development of various change teams made up of counseling center and residence hall staff members. The activities have slowly evolved from those handling assorted crisis resolution and management situations to those whose primary goal has been organization assessment and organizational change through consultation and advocacy.

Exploration

Once the contract has been established, the *exploration or information gathering* step is continued. It is apparent from our discussion that this step really begins during the initial moments of your response to the request for intervention. Your client is giving you valuable information about his/her organization or group from the first moment of contact with your agency, but it is important to distinguish between general information gathered to determine the appropriate type of intervention (such as educational program, consultation, or advocacy) and the problem-solving exploration aimed at resolving the specific issue at hand. General information gathering involves the process of understanding and assessing the fit between the specific skills which your agency possesses and the skills needed by the potential client. Only after you have determined there is a "fit" and have chosen, tentatively, the proper approach, is it appropriate to

begin indepth exploration of the organization. One more cautionary note: Department heads at many institutions of higher education frequently delegate the task of planning staff development activities and it is with that delegate that you may first confer. It is essential that you contractual agreement be approved not just by that delegate but also by the chief administrator of the agency before any outreach or advocacy effort procedes to indepth information gathering.

An illustration of information gathering procedures may be useful at this point. We received a request from an academic department chair for an alchol and other drug abuse information workshop, along with some information about the various services offered by the counseling center for their faculty, counselors and advisors. Preliminary questioning over the phone revealed that several faculty members were concerned about a handful of students who were suspected of having drug abuse problems that were affecting their academic performance. Their initial solution was for us to present an hour-long informational workshop. They said the department was rightfully concerned but not entirely sure how to respond.

Rather than proceed with the requested workshop, our staff suggested that further exploration, through an informal interview with the interested departmental personnel, would be helpful. We explained that we would like to ask some routine questions to determine the content for a "tailor-made" workshop. During the interviews, with some assertive probing on our part, several faculty members expressed concern that the most troublesome issue was not really drug abuse, but an annual problem caused by a vague and ambiguous departmental policy statement. Their real concern centered on the fact that some graduate students who were not making significant progress in their studies were being allowed to continue in the program. For some time, these faculty members had advocated a clear policy statement with criteria for "significant progress" and consequences for failure to maintain the progress, but these efforts had proven fruitless.

As a result of extensive exploration and more data gathering, the counseling center staff recommended that the department form a change team, made up primarily of department personnel but including counseling center staff, as advocates for a full review of the policy statement and to establish, if necessary, a subsequent proposal for a new policy statement.

What was significant about this process was that previous attempts had been made without success. The counseling center staff members as outside advocates provided influential imput during departmental policy-making meetings, and the change team later acknowledged that the change took place because of that objective, disinterested advocacy. They stated that without our initial exploratory intervention and subsequent advocacy activities, the interested parties would not have pursued the issue due to their learned helplessness. Historically,

no one in the department had followed-up after the numerous attempts to identify the problem, nor even suggested that anyone (such as a committee, task force, or change team) take responsibility for proposing solutions to the problem. Following the intervention, many faculty members felt much relief and a renewed sense of power and control. They admitted that the requested workshop on alcohol and other drug abuse had been discussed quite thoroughly behind the scenes, and, not surprisingly, that departmental enthusiasm, energy, and mid-level support for the requested program had been minimal at best.

The above example describes exploration prior to the establishment of a contract. The following example describes how information gathered after the establishment of a contract was used to fulfill the specific goals of the contract.

The counseling center was asked to consult with a particular student services office where many personnel were experiencing dissatisfaction and morale problems. Through preliminary information gathering, it was determined that a full organization assessment was needed and the director of the organization fully supported that assessment. It was agreed that the consultants would interview each staff member to determine what each individual considered to be the causes, reasons, and possible solutions to the existing problems. The contract called for the development of a standard questionnaire which all staff would answer during face-to-face interviews. The answers, which would be anonymous and confidential, were to be compiled and synthesized by the consultation team into a written summary of historical problem areas, current problems, and recommendations. This summary was to be submitted to the director who was to be debriefed by the consultation team and copies were also to be distributed simultaneously to all interviewed employees. It was agreed that the contract would include the final step of an option for negotiating further consultative activities with the organization after presentation of the recommendations.

In this case, all the goals of the contract were fulfilled and the consultation proceeded along the proscribed path of the contract and, at a later date, the organization negotiated with the team to help assist with the design of the program to implement the recommendations.

Getting Down to Cases

Case conceptualization integrates information obtained during the exploration into a problem-solving strategy. Ideally the diagnosis should involve consultation with a team of professional colleagues skilled in the outreach/consultation/advocacy area (Williams & Miko, 1986) so that the information obtained can be shared with other experts to brainstorm ideas, suggestions, different perspectives, and possible solutions. Following this collegial consultation, it is also

helpful to present the integrated information (including the assessment and diagnosis) to the change team. Allow the team time to digest and process the information with you, and then facilitate the discussion process.

With the department that had morale problems, the change team used the consultative skills of others in the counseling center to formulate the intervention, including the development of the initial contract and the subsequent development of the written document presented to the organization. The team met with the director to spell out the recommendations and specific suggestions about how to implement them. The recommendations advocated increased focus on the development of more humane working conditions and schedules, the reduction of unfair practices in hiring policies and vacation and holiday staffing policies, and the re-examination of several important department-wide decisions.

More than Two Aspirin

Formulating an intervention strategy requires the change team's agreement on the most appropriate methods to meet the goals established by the assessment. The change team can best achieve this by: 1) defining the criteria for strategy selection; 2) developing alternative strategies for achieving the goals; 3) considering and evaluating the consequences for each strategy; 4) choosing the most desirable strategy by examining the potential side effects, barriers and sources of resistance; 5) re-assessing the roles and responsibilities of each change team member; and 6) allocating the necessary resources and time necessary to implement the selected strategies.

We could have tried several intervention strategies with the disgruntled employees. We decided on fact-to-face interviews because we had learned that the morale problems might be related to the impersonal nature of the organization, its size, and scheduling problems that kept some personnel very isolated and out of touch with the organization. Paper and pencil surveys would have served to maintain that impersonal flavor; an opportunity to express one's views and frustrations to an attentive expert helped to dispel it.

And Finally—Action

We will describe the *implementation* step through examples of actual advocacy activities. As we mentioned previously, we maintain and nurture an on-going, consultative role with the university residence hall staff. At first, they called on us primarily for various crisis interventions, usually on an emergency basis (level 6 or 7) interventions. As the relationship between their staff and ours deepened, our interventions became more developmental and preventive in nature (levels 1 through 5), and we became much more involved as change agents. We added our expertise about students' developmental tasks and needs to theirs about their residents and their organization and together we formulated interventions to address

whatever was at issue. Gradually, carefully, we also became residential life advocates.

Particularly in outreach services, we view implementation as an ongoing process, in that we maintain a lengthy relationship with the client as consultants or as co-members of a change team. This allows us to continually assess the environment for areas in need of change. Because of our well-established relationship with the resident hall staff we were directly involved in the planning and expansion of their training program (including team building skills, crisis intervention skills, stress management skills, alcohol and other drug abuse issues). We introduced, gained support for and now maintain a regular system-wide involvement of counseling center staff in systematic organizational assessments and formal organizational consultations with specific residence halls and their staffs. Today, we have direct input into various formal policy and procedures implemented within the residence hall administrative structure.

Another example of advocacy intervention on our campus is the development of a campus-wide substance abuse education program. The counseling center played an important role in integrating input and data from other campus resources and providing the results and further information to the university administration concerning the need and necessary procedures for a comprehensive program. The administration was receptive to the notion of a program, but they wanted enough information to design an effective, long-range program. A change team was created. Our members are a wide-range of critical student affairs personnel with "front-line" experience with students, charged with providing the experientially-based knowledge and understanding of the developmental needs of the college student population.

As we continued to advocate, the administration became increasingly supportive of the development of a specific and comprehensive needs-based substance abuse prevention program that will include a wide range of services to assist students at all seven levels of need. These services include education workshops and written materials about the physical effects of alcohol and other drugs, driving and the use of state-altering substances, the disease model of alcoholism, and information about individuals and how to deal with personal feelings when a significant other has an abuse problem and refuses help. Finally, a referral program was established for students who have been identified as having a substance abuse problem or for whom substance abuse problems are suspected (level 6 or 7).

So, How Do You Know How Well You did?

Evaluation of outreach activities involves several tasks such as 1, monitoring the process of change through the compiling of relevant data; 2) assessing periodically the outcome of the change plan; 3)

monitoring and acknowledgement of goal achievements, 4) re-cycling to earlier stages or steps in the outreach process as necessary by re-examining goals, modifying strategies, or mobilizing additional resources, and 5) stabilizing successful implemented changes by building in support systems, initiating periodic *follow-up* activities, and maintaining necessary resources

Commencement

As with clinical work, the *termination* step of the outreach process is in many ways the most overlooked, yet it is as important as any other step in the process. Termination means acknowledging, rewarding, validating and summarizing the project and its progress. Brown (1985) describes termination occurring under two circumstances: when the goals have been reached and when it is apparent that the goals *cannot* be reached. Our experience has been that the change team's debriefing at the project's end can be a pleasurable and necessary learning experience. Another important task in termination is mutual understanding among change team members of the reasons for termination, that it is a way for the change team to feel a sense of accomplishment and closure. Finally, though you design the intervention so that it will remain in the system structure after you are gone, always leave the door open for further intervention. It is often necessary.

Summary

The advocacy and consultative roles are relatively new ones for most college counseling services and we are grateful for the dialogue and exchange of information this monograph provides. As our contribution to that exchange, we have discussed outreach services in general and advocacy and consultation in particular, we treat them here in perspective with the overall changes within the mental health field as it has evolved these past twenty-five years. We have provided the model we use to identify seven levels of need for assistance and to guide our choices and decisions in timing and type of intervention, and we have described a working model of the outreach process that we use at the University of Texas at Austin.

In our view, advocacy and consultation services are a natural and necessary result of our discipline's acceptance of responsibility for more than the passive, traditional services of the past. We have shared with the reader how our center's services have changed as our philosophy has moved from one of passivity to one of thoughtful and timely action and we are eager to learn of others' experiences. One impediment to this learning is terminology. The common confusion and misunderstanding of terms used when discussing outreach activities unnecessarily complicates exchange of ideas and experiences and we suggest here definitions that have been useful to us. Moreover, we advocate the adoption of standard definitions for outreach, advocacy,

and consultation, so that our future dialogues are not hindered and complicated by linguistics.

How many times per day do we tell our clients and staff that change is difficult and frightening but also necessary? It is easier to preach than to practice. The changes in stance and philosophy that face most counseling services today are difficult. But necessary. Advocacy may be one of the most necessary of them all.

References

- Brown, D. (1985). The preservice training and supervision of consultants. *The Counseling Psychologist*, 13 (3), 410-425.
- Conyne, R.K. & Clack, R.J. (1981). *Environmental assessment and design*. New York: Praeger.
- Domke, J.A., Winkelpleck, J.M. & Westefeld, J. (1980). Consultation and outreach: Implementation at a university counseling center. *Journal of College Student Personnel*, 21, 211-214.
- Drum, D.J. (1987). Counseling psychologist or hefflelump? *The Counseling Psychologist*, 15, 280-286.
- Gallesich, J. (1982). *The profession and practice of consultation*. San Francisco: Jossey-Bass.
- Gallesich, J. (1985). Toward a meta-theory of consultation. *The Counseling Psychologist* 3 (3), 336-354.
- Lerman, C.A. (1983). Internal consulting in higher education: Starting from the university counseling center. *Consultation*, 3 (1), 4-10.
- Lippitt, G., & Lippitt, R. (1978). *The consulting process in action*. La Jolla, CA: University Associates.
- Ulschak, F.L. (1978). Contracting: A process and a tool. *The 1978 annual handbook for group facilitators*. LaJolla, CA: University Associates, 138-142.
- Williams C. & Miko, K. (1986) Seminar on Consultation. University of Texas at Austin Counseling & Mental Health Center, January 16-17, 1986.

Chapter Six

Advocacy and Outreach Through Consultation: Applications to Educational Settings

Clarence D. Johnson, & Sharon K. Johnson

Advocacy and consultation are complementary processes which are essential to quality school guidance programs. Counselors are student advocates who use consulting skills to enable all students to succeed in learning, working, and relating to others. In order to understand counselors as advocates, the purpose of the guidance program must be clear to those involved. It is the guidance purpose which answers the question, "Advocate for what?" or "Advocate to what end?"

This chapter begins with a discussion of the role of the counselor as student advocate in a guidance program. Its thesis is that an effective guidance program must reconceptualize the purpose of guidance (Johnson, Johnson, & Gerstein, 1987). It proposes a paradigm shift from a guidance program consisting of a set of services provided by counselors to a program that is based on student results or competencies. Next, twelve essential program elements of such a results-based guidance program are presented. Concrete examples illustrating in-school and out-of-school advocacy illuminate these concepts. Finally, the paper concludes with some suggestions for matching strengths of professional staff with goals of a results-based guidance program.

The intentionality of guidance and other pupil services programs is to ensure that all students benefit from the educational opportunities

available to them. In order to accomplish this purpose, it is necessary to identify the desired result we hope to achieve with each student. It is relatively easy to gain consensus with other adults on the results desired for students if those results are clear and are student-focused. Once agreement is reached on the results, all of the adults in the student's life can work together to achieve them. The process of advocacy is based upon the premise that, as professionals, counselors can make a difference in the educational system (through their work with the school, the family, and the community) to provide the student with the best possible chance of success. A mistake made by some guidance professionals is to always "line-up" on the side of the student against other professionals, family members, and/or community members. The creation of an "us" and "them" environment (whether it be school vs. family, adults vs. student, educators vs. community, or guidance vs. other educators) saps energy and is detrimental to the student's reaching his/her goals. Therefore, a necessary prerequisite to a student-advocacy approach in guidance is to develop a well-defined and credible program of student competencies that can be articulated to others. Then a process of consensus-building can be used with significant adults regarding the goals of the program. This approach combines energies and resources of all adults to reach the agreed-upon goals. From this perspective, advocacy is the process of defining desired student results and consulting with other adults to enlist their assistance in moving all students in the appropriate direction. This definition extends advocacy beyond pleading another's cause in support of something (Guralnik, 1984) and further articulates the definition (Morales & Sheafor, 1986) which includes "the utilization of a whole repertoire of strategies aimed at assisting others." The processes of consultation and outreach are skills used by counselors to enlist others in the process of advocacy for student groups and individuals.

The counselor-as-advocate has responsibility to create and implement a guidance program that focuses on development of the student. Some counselors will have to make a paradigm shift from the traditional approach of defining guidance in terms of what counselors do, (e.g., assist students to plan, implement developmental classroom units, etc.) to defining guidance by describing the competencies (skills, attitudes, knowledge) students will gain. This shift from conceptualizing programs as providing services to programs that are results- or competency-based (Johnson & Johnson, 1982, Whitfield, 1986) allows counselors to organize guidance efforts around pre-determined immediate, short-, and long-range student results. This approach is different from the more traditional guidance-by-objectives approach. Such a change in perspective redirects the focus of guidance from a set of activities and services provided primarily by counselors to specific goals for all adults who are working with student groups and individual students. Recent publications have

begun to address student results as a focus for the development of comprehensive guidance programs (Hotchkiss & Vetter, 1987)

In order to understand how this shift affects the function of advocacy in guidance programs, two disparate perspectives of management are considered (Kiersey & Bates, 1973). One approach is for all *processes* to be held constant to ensure equal opportunities for each student, the other approach argues that the desired *result* must be held constant to ensure equity in the attainment of competencies by each student. When the desired result is held constant, the processes must be allowed to vary. If the desired results are for eighth-grade students to demonstrate competencies in listening to peers, many processes will have to be used. For example, some students may learn in a classroom setting while others will learn better in small groups. For those who do not learn well through auditory means, other methods may have to be used, such as peer tutors, working one-on-one, providing a community experience in which it becomes important to listen to peers, or working with the parents to provide specific experiences. On the other hand, when the process is held constant so that all eighth-graders have an equal opportunity to learn what is offered, some will learn through the single process and some will not. For example, if a counselor makes a large-group presentation on listening, some will learn what is expected, but others who have a different style of learning (Dunn, 1982) will not learn unless additional and different experiences are provided. To expect that an individual counselor can singlehandedly provide all of the necessary experiences for each student is impractical. Once the desired student competencies have been defined, the counselor must then utilize a variety of advocacy approaches, using many different educational resources including other adults in the school and community, to provide the opportunities necessary for each student to succeed.



Figure 1
Elements of A Competency-based Guidance Program

Competency-based Guidance Program Elements

To facilitate the shift in focus, the authors have defined a framework to provide structure and direction to programs (Johnson & Johnson, 1982).

The 12 elements of a competency-based guidance program are interrelated and based upon a statement of purpose. The first five elements define the framework of results for the guidance program; the other seven are processes used to implement the program.

1. **PURPOSE** The statement of purpose clearly presents why the guidance program exists within the school system, i.e., what the program will contribute to students. In its brevity of one or two sentences, the content will disclose the intentionality of how students will be different because of guidance.

2. **PHILOSOPHY** The philosophy consists of a set of belief statements that provide guidelines for counselors and administrators to develop, implement, and evaluate the guidance program. The statements might address issues such as the belief that guidance is for all students, is based upon expected developmental stages, that program management will be results-based, that counselors will renew as well as acquire new competencies, and that professional ethics will be followed.

3. **CONCEPTUAL MODEL OF GUIDANCE** By using a conceptual model of guidance, the content of the guidance program is easily delineated. The authors use the conceptual model of guidance developed by Wellman (1964) which simplified the guidance program content into three domains of student results: (1) educational domain (learning to learn), (2) career/occupational domain (learning to work), and (3) personal/social domain (learning to relate to others).

4. **GOALS** By using the three domain categories in the conceptual model, it is possible to limit the program to three comprehensive goals which are written in terms of student competencies—not in terms of providing services or in providing opportunities for students.

5. **COMPETENCIES** A competency is a developed knowledge, attitude, or skill that is observable and can be transferred from a learning situation to a real-life application. Competencies are measureable student outcomes.

6. **MANAGEMENT** Managing for results centers on allocating resources to meet specified goals. These resources include personnel, materials, and facilities. Again, the difference in the intentionality must be kept visible; the primary concern is how many students will benefit from a given activity. The management system recommended (Kiersey & Bates, 1973) is a reciprocal model in which both the principal and counselor assume responsibility for the results the counselor will contribute.

Counselor

Produces and Negotiates
Results Agreement

Produces and Negotiates
Results Plan

Implements Plans

Produces Evidence of Results

Acquires New Behaviors

Principal

Audits and Appreciates Results
Agreement

Audits and Appreciates Results
Plan

Monitors and Appreciates
Activities

Validates and Appreciates
Evidence of Results

Coaches New Competencies

(Although this model may appear to be hierarchical, in fact, it is based upon participative management philosophy.)

7 RESULTS AGREEMENT Each counselor produces a results agreement which specifies what guidance results the individual counselor will contribute for all students, specific students, staff, and parents. The six-part results agreement includes

(1) Student program results comprise the major part of the agreement and include a description of the population and competencies to be addressed. For example, all ninth-grade students will demonstrate educational planning skills, or all tenth-grade students will describe the competencies required to find, keep, and leave a job.

(2) Those competencies defined for students who are self-referred or referred to the counselor by others include problem description, identifying ways and consequences of ways to solve the problem, choosing acceptable solutions, and delineating steps in problem solution.

(3) Counselors are expected to provide competencies for staff members through inservice training and staff consultation as a means of helping students. These may include activities such as instructing teachers on how to use learning style information with students, helping staff to listen to students' feelings and to react appropriately, and instructing staff on developmental tasks of students and adults.

(4) Counselors will plan, implement, and evaluate programs for parents in such areas as setting up learning climates in the home, listening to their students, recognizing and handling stress in children, and understanding developmental stages in children.

(5) All counselors should be on a planned competency-renewal program. Areas for renewal and acquisition could include group counseling skills, competencies in consulting with staff, or competencies in helping parents establish a learning climate in the home.

(6) Assigned tasks are those activities that a counselor is told to do—those tasks which are necessary for the functioning of the school but are not related to the guidance program results, (e.g., bus duty, student records, or administering the testing program).

8. **NEEDS DATA** At times, counselors and administrators may require validation of the need for specific results or processes. To do this, counselors may choose to complete an assessment of needs prior to completing their plan. The needs assessed should be based upon the predetermined student competencies (Johnson, 1982).

9. **RESULTS PLANS** After the principal and counselor have agreed on the results the counselor will contribute, counselors next complete and negotiate with the principal an individual plan on how they will get their results. The plan includes the competencies, activities, place, completion time, who will do what, materials to be used, criteria for success, and how they will validate their efforts.

10. **STUDENT MONITORING** There are many ways that students' acquisition of competencies can be recorded and monitored. Some guidance programs use an "Educational and Career Planning Folder." Others record the demonstration of competencies using computers. In schools where there is an advisement or mentoring program, the advisor or mentor can record when the desired skills were demonstrated and, in some systems, parents verify competency demonstration. It is important that when the student demonstrates the competency, a responsible adult validates the demonstration.

11. **ADVISORY COUNCIL** A Guidance Advisory Council is a representative group of parents, administrators, teachers, and students which meets with the counselor for the purpose of auditing the guidance program results and making recommendations to the principal or the Board of Education (Johnson & Johnson, 1973).

12. **MASTER CALENDAR OF EVENTS** The Master Calendar has a schedule of the year's guidance program activities and serves as a means of telling the students, staff, and administrators the many experiences counselors provide which help students acquire the desired competencies.

Once the guidance program has been developed, implementation must become an assertive outreach effort in which the counselor-as-advocate enlists the participation of adults within and external to the school. The actual skills counselors use with individuals and with groups of adults have been delineated in models of consultation (Brown, Prejzowsky, & Shulte, 1987; Dinkmeyer & Carlson, 1977; Schmidt & Medl, 1983; Kurpius & Brubaker, 1976; Umansky & Holloway, 1984).

Implementing An In-school Advocacy Program

The counselor expands advocacy for all students through implementing the results-based guidance program in a variety of ways including providing training and consultation with staff to increase student learning, describing individual student and group behaviors in order to develop interventions, and through implementation of case-management strategies. As a result of counselors' efforts, teachers, administrators, parents, and community members become an integral

part of the guidance team—assuming responsibility for providing guidance-related experiences for students. Thus, the guidance program can and should be a total school, home, and community effort.

Teachers: One of the most important groups with which counselors can serve as advocates for students is teachers. Since counselors do not have daily access to students, an effective implementation strategy for reaching large groups is to infuse guidance information throughout the curriculum. Through the infusion process, counselors have an opportunity to work closely with teachers in articulating student needs, guidance goals, and individual student differences. This provides a vehicle for collaboration with teachers so they, too, take pride in the student results. Examples of such practices drawn from the field illustrate how this advocacy function works.

Case Study 1: One of the student competencies a counselor had in her Results Agreement was "Each graduating senior will demonstrate competencies in preparing a resume for employment, for applying to an institution of higher learning, or for both." In order to achieve the results, the counselor met with the English Department Chairperson and negotiated a four-day unit on preparation of resumes with all twelfth-grade students. Using the PASSPORT (Charner, 1984) materials, the counselor co-instructed the classes one day every other week for eight weeks. The English teachers were responsible for correcting all resumes for accuracy and the counselor corrected each for content. The student results were achieved: each student had a resume. In the process, the teacher became aware of the variety of skills students needed to develop a resume and how important the skills were to students leaving high school for work or higher education. The following year the teachers incorporated the unit into the course while the counselor became a resource to help when requested.

Another implementation strategy which enlists teachers as co-advocates for students is the development of staff inservice activities which focus on individual student needs, learning styles, or developmental issues. For example, an activity designed to help teachers understand learning styles (Gann, 1987) can be presented to teachers in groups organized by subject matter or by grade level. This knowledge provides teachers with a different perspective of individual students in the classroom and also provides a vehicle for communication among teachers and between teachers and parents when discussing individual students. By providing a model of learning styles which is usable within academic and nonacademic areas, teachers are encouraged to share perceptions in order to help the student. It also provides a shared understanding of student learning characteristics which can be invaluable when a counselor consults with a teacher to articulate an individual student's unique needs.

Case Study 2: This case study of a staff inservice activity demonstrates the complementarity of guidance and advocacy. As part of the Results Agreement, one counselor indicated that "All teachers will demonstrate knowledge of personality type as a model for acknowledging individual differences." The district was shrinking in

student attendance, causing one school to close and two faculties to mesh into one school. There were territorial disputes as new departments were formed, classrooms moved, and a new administrative staff assumed leadership. This counselor used a Myers-Briggs (Myers & McCaulley, 1985) workshop to encourage teamwork, to recognize a variety of personality styles on the faculty, to form committees based upon individual styles and contributions, and to facilitate communication. As a result of this inservice workshop, staff morale improved dramatically. As a spinoff, the teachers learned a great deal about the personality type characteristics of themselves and others. Knowledge of personality type was found to be valuable in understanding their students. The teachers' interest and skills in identifying individual student's strengths and contributions was heightened and the counselors' expertise became a resource used to benefit staff and students.

Another important advocacy role within the school community is to present the counselor's perspective on the whole child. Recent initiatives have focused attention and teacher efforts toward excellence in academic achievement. A number of well-researched reports and politically-motivated reports have identified the need to promote higher achievement by students (National Committee on Excellence in Education, 1983). Guidance personnel often find themselves in a position to help parents, teachers, and administrators balance the need for academic excellence with the need to address other aspects of student growth and development. The pressing mental and physical health needs of students are apparent when current statistics on teenage pregnancy, adolescent suicide, child abuse, sexually-transmitted disease, and substance abuse are examined. Teachers and administrators can feel overwhelmed by the diversity and magnitude of the problems faced by students. Consequently, they may be tempted to respond by concentrating all their efforts on curriculum and instruction in order to achieve academic excellence while leaving mental and physical needs of students to the more qualified professionals—the counselors. It becomes imperative, then, that counselors have skills to help teachers and administrators identify ways to address "the total student" without sacrificing their professional integrity. Recognizing and legitimizing the teacher's influence on students may be enough in some cases to cause the teacher to provide needed emotional support for an individual student. Teachers who remain in education are interested in their students and, with encouragement and support from a counselor, are willing to address mental health issues related to student progress.

Case Study 3: One such way in which a counselor served as student advocate is given in this example of a tenth-grade female student. She was referred to a high school screening committee for consideration for Special Education. Several Special Education teachers, a speech therapist, an administrator, a psychologist, and the counselor were present. The student had attended private schools for her entire

educational experience but was referred to the public school because of her need for additional academic assistance. The student had a history of epilepsy. The psychological evaluation, educational assessment, and teacher input were reviewed by the committee. The student demonstrated excellent social skills, was doing well in two elective classes, but was failing two academic classes. The committee, in an effort to provide the remedial academic assistance that the student needed, was considering a plan to remove the student from the elective classes and use those periods to provide tutoring in academic areas. It was the counselor who was able to help the committee reframe its ideas to find ways to provide academic assistance while at the same time encourage the student's participation in her favorite subjects—choir and team sports. In the committee's view, the student's academic achievement was paramount and yet, if all the classes in which the student excelled were removed, there might be little motivation for her to maintain her cheerful attitude toward school and her acceptance of the help provided. When the emotional and social needs of the student were considered, the resultant plan for the student was entirely different from the first plan suggested. In addition, the resultant teacher and administrator awareness of the total student strengths and needs will have lasting effects when other student needs are reviewed.

Administrators: In addition to working with teachers as a student advocate, counselors may be called upon to intervene for the student with the administration. When a student has been referred to an administrator for an infraction of a school rule, the counselor can be counted upon to represent the best interest of the student during the subsequent decision-making process. It is important for the administration to be aware that one of the central goals of the guidance program is personal/social responsibility. Therefore, it is appropriate for counselors to intervene, developing alternative interventions which entail reinforced behavior changes, involving parents, and identifying causes of the infraction. For example, when a student is excessively tardy or absent, there may be a variety of contributors (e.g., late-night work hours, helping a single parent with younger siblings, physical or sexual abuse, or maybe the student is experiencing a growth spurt and lacks energy). The counselor's involvement may be more important than any punishment extracted for the infraction, since the undesirable behavior may be the student's way of asking for help.

Case Study 4: A junior high school counselor included in his Results Agreement that "Students identified as AT-RISK because of poor attendance, failing grades, and aggressive behaviors will show increases in daily attendance and homework completion and a decrease in formal referrals." The process chosen to reach the result Mentoring (also referred to as Adopt-A-Student). The concept of Mentoring was to enlist volunteer faculty members to mentor from one to three At-Risk students. The mentors included teachers,

counselors, and administrators. The counselor developed, implemented, and evaluated inservice activities for the mentors which included meta-listening, personality type, examining learning styles, and conferencing with parents. The administrator identified the students and had teachers select their mentees. The mentors checked daily to make sure their assigned students had their homework and were following school rules and regulations. If a student was absent, the mentor called the home and, if necessary, made a home visit. If the student was having difficulty in a class, the mentor checked with the teacher, met with the student, and helped the student acquire the desired behaviors or complete the required homework. After one semester, the incidences of failure, truancy, and referrals for discipline were significantly decreased. In addition, the program was transferred to other schools in the district for implementation.

Parents: Being student advocates extends counselors' contributions to working with parents in a variety of ways. In the primary grades, counselors may provide information through small-group meetings on topics such as developmental tasks, discipline, learning styles, establishing home rituals, and social skills. Parents of students in the upper elementary grades often request help in knowing how to teach their students organizational skills or in establishing the rituals of homework. Many parents of middle and junior high school students appreciate information and skills that address transitional behaviors of students moving into adolescence. Parents of senior high school students often want information on career and college planning, scholarships, and college admission time-lines. Providing parents with information and skills is the first step in helping them understand and accept the unique differences of their individual students. These outreach efforts with parents facilitate the process of individual advocacy when counselors meet with families to clarify communication issues related to the school. When parents perceive that all the responsible adults in their children's lives are working together to help the students achieve, the students' cause is better represented.

Case Study 5: In an individual conference with a parent who was concerned about his son's academic achievement, the counselor listened carefully to the parent's situation, expectations, and frustration before addressing the son's behaviors. This high school student was excelling in Art, Music, and Humanities but was experiencing difficulty with Math and Science. The counselor was able to identify that the parent worked for a large computer firm and had always enjoyed Math. The father began to fully comprehend the nature of the difficulty when the counselor used computers as a metaphor for the right-brain dominant pattern of learning demonstrated by the son. "Your brain operates much like a digital computer, while your son's brain is more like an analog computer." Once this understanding was reached, the counselor, father, and son were able to develop a plan which encouraged the student's strengths and yet provided additional help in his areas of weakness.

Implementing Out-of-school Advocacy

Counselors can expand their role as student advocates by moving beyond the school. Counselors can facilitate linkages with groups and individuals external to the school to become part of an adult advocacy network for students. In particular, private-sector groups such as business organizations may have a variety of complaints about how students are not adequately prepared to become part of the work force. By forming linkages with these groups and seeking their consultation and assistance, they become part of the solution to the problem as well as helping the counselor provide activities to reach pre-determined guidance competencies.

Business groups are often willing to develop community projects that provide student internship experiences, job interviews and feed back opportunities, or have personal departments review and provide feedback on student-completed application forms. These are areas in which the business community has expertise; by sharing resources, they also share ownership for the results. In the process, adults who would otherwise be critical of students become advocates and helpers in making sure the results are attained. An effective way to maintain the interest and a high level of involvement is to periodically report to the involved groups, informing them of how their efforts as part of the educational team within the community are having a positive impact on student results.

Community agencies and service organizations may have goals similar to those of the schools and while they sympathize with the need for students to gain specific skills, their staffs are frequently overworked and underappreciated. A counselor can link with these groups through an active advocacy role in which the unique viewpoint of the student is presented as a way of enlisting needed support for all students.

Case Study 6: One recent case illustrates this principle. A student was absent from school because the electricity had been turned off in the home. The children in this family were temporarily "farmed out" to other family members and friends until financial resources could be found to pay the electricity bill. These children needed an advocate to represent their needs in a situation over which they had no control. The counselor was in a position to articulate the students' losses, the missed educational experiences, and the effects of being uprooted, all of which had lasting effects long after the electricity had been restored.

The individuals charged with allocating community fuel funds, city/county/federal emergency funds, and other sources of emergency aid are frequently in the position of having to prioritize requests for help. The counselor's intervention helped them understand the need for timely assistance because of the effects on the children's education. In this particular situation, the adults in the community who heard the counselor's appeal indicated that they had never really

considered in the educational effects of such a situation and would, in the future, make an effort to connect with the schools when processing requests that involve school-age children. Not only did the counselor help an individual child, but also enhanced the role of student advocate where major decisions are made.

The counselor can provide a vital link between the school, parents, and other community members. Guidance resource centers with their updated career information, college information, and job banks can offer a valuable resource for adults as well as students. Use of a career center during non-school hours by community members is one way to educate the public about the resources available to students. At the same time, community members become more aware of the specific needs of students for accurate, updated information that may not be available through classroom texts. Information from community sources—businesses, agencies, and organizations—becomes an important link between students and the world in which they live. As active linkages with businesses are established, counselors become more aware of opportunities which may be created in the community to benefit students. Real world experiences help students understand the relevance of what they are asked to learn in the classroom. Improved student behavior is often the result of such experiences.

Case Study 7: Linkages with businesses and organizations can also be made through negotiated trade-offs. In one case, a large company adopted a school and worked closely with the counselor on a continuing basis to provide experiences for students. In exchange, the counselor provided access to the guidance center during non-school time for the company employees and assisted with company workshops on communication, time management, and other guidance-related competencies. The linkage provided a cadre of interested adults who understood the value of the experiences offered to students and were actively involved in providing real-life experiences for students. Company officials reported better employee morale as the result of involvement in the joint project and those adults became knowledgeable advocates for student experiences within their companies.

Resources within a community are numerous and can be tapped to help students acquire a variety of competencies in learning, working, and relating to others. Identification of available resources will vary depending upon the size and diversity of the community. Service organizations such as the Chamber of Commerce, Rotary, Lions, and Exchange Clubs; professional organizations associated with law, business, and medicine; special-interest groups; churches; ethnic associations; and unions are only a few of the community groups which are interested in the youth of the community. The counselor advocate may have to be selective in approaching outside groups to assure that community involvement will help students gain specific skills and also to prevent raising expectations and then being overwhelmed with too many resources to use them effectively.

Using Consulting Skills to Mobilize Groups and Public Support

One of the most effective strategies for building advocacy for students is the establishment of Guidance Advisory Councils (Johnson & Johnson, 1973) at the school level and at the district level. A Guidance Advisory Council should be composed of representatives from various geographic areas, socio-economic levels, and ethnic and racial groups in the community. Also, the teachers, students, and administrators should be represented. These groups are charged with auditing guidance program results and recommending priorities. They can also be used as a sounding board for program goals and competencies. Asking for feedback from their respective groups encourages discussions about the guidance program with other adults. If properly selected and oriented, the Council can become a strong program force because its members are well-educated about the program and are in a position to make recommendations to the Board of Education during budget hearings and to administrators at the school level. A well-informed, supportive group of adults who can clearly articulate guidance goals in the school and larger community creates visibility, credibility, and advocacy that could not be gained by counselors alone.

Advocacy demands communication and one of the most powerful communicators available is the media. Each community has a variety of media to use to inform people of current happenings, promote involvement, and encourage community support. Counselors can use the media to educate others about student needs. Outreach efforts are only successful when they reach the targeted constituents. Therefore, although the traditional methods within the schools such as parent newsletters and daily announcements may continue to serve some purposes, they are ineffective vehicles when used to motivate and educate students, parents, and other community members. Hence, it is suggested that counselors prepare and submit frequent newspaper articles to provide information and to provide visibility of guidance program efforts.

In some communities, newsletters provide a "Counselor Corner" column which can be used to discuss a variety of topics related to student needs, parenting skills, and educational issues. Community television stations often provide opportunities for informational programs related to educational concerns. School newspapers are a valuable way to reach students and teachers within the school—regular columns, articles, and letters to the editor can be used to educate others on guidance-related issues. A videotape which articulates the guidance program purpose and goals, current progress, and student needs can be used for presentations with parents, visitors to the guidance program, community groups, and staff. Community groups, such as local ministerial associations, professional groups, and

service groups often have monthly newsletters and are happy to have relevant articles to include in their publications. Although preparation of information for the various media is time-consuming, the number of individuals who can be enlisted to help students justifies the time it takes. When counselors keep the desired results in focus, the need to involve others in reaching the goals makes the use of media an important endeavor.

Matching Professionals to Issues

In order to implement a guidance program for ALL students, counselors need to call on their individual strengths and will have to provide a variety of approaches, each needing an in-depth background of knowledge. Since it is likely that many counselors would not have the necessary knowledge to work with all subpopulations, alternative arrangements have to be made. Program development efforts which focus on reaching all students increases the opportunity to build student advocacy within the total school community. From a broader perspective, utilizing the special interests and skills of counselors in the most effective organizational structure multiplies the opportunities to build a climate of advocacy throughout the school and community. Two such strategies are differential staffing and special programs.

The purpose of using differential staffing is to allocate available resources in such a way as to help all students to acquire the knowledge, attitudes, and skills delineated in the guidance program. Differential staffing matches the strengths of individual staff members with the desired results. There are numerous ways that counselors can assume responsibility for different results. Assigning students to counselors based upon the students' individual goals (e.g., college-bound, vocational, at-risk students, etc.), assigning counselors to specific domains (e.g., educational planning, career/occupational planning, personal/social growth), and giving one counselor primary responsibility for community outreach and another responsibility for parent involvement are all possibilities within the context of differential staffing. Decisions should be made using information on the strengths of the guidance staff and the school staff, the school needs, and community and parent commitment. The best way to develop assignments is for the guidance team as a group to come to consensus; thus, everyone is committed. It is also important to reassess the management decisions annually and/or as staff changes occur. From a broader perspective, the second strategy involves the development of special programs such as teacher advisement, mentoring, adopt-a-student, and homeroom. In each of these programs, the counselor should play a key role as advocate and consultant. Counselors develop curriculum to be used, plan, implement, and evaluate the staff inservice component, and monitor teacher-student assignments, making changes as necessary. The curriculum consists of guidance units such as how to study, how to take teacher-made and

standardized tests, how to take responsibility, how to make and keep friends, and how to plan an educational program. Counselors' contributions to teacher advisement programs are well-documented (Myrick, 1987) and indicate that advocacy for students can be extended to teachers becoming advocates.

Summary

Advocacy for students is the prime reason for having counselors in the school system. The processes associated with being an advocate are many; however, they are definable and can be learned. The first step is the development of a comprehensive guidance program that has as its target the student as the primary client. All other program elements including the activities, processes, or strategies used by counselors must be considered as a means to the end, to ensure that students reach their goals. As the key to advocacy development, the counselor provides leadership in generating school and community support. Using the leadership skills of consultation and outreach within the school and in the larger community to achieve advocacy for students improves the students' chances of success. These linkages between the school and the larger community assist ALL students to acquire the competencies necessary to make successful transitions from school to work, to higher education, or to a combination of both.

References

- Brown, D., Pryzwansky, W. B., & Shulte, A. C. (1987). *Psychological consultation: Introduction to theory and practice*. Boston: Allyn and Bacon, Inc.
- Charner, I. (1984). *Passport*. Washington, DC: National Institute for Work and Learning.
- Dinkmeyer, D. & Carlson, J. (1977). Consulting: Training counselors to work with parents and administrators. *Counselor Education and Supervision*, 16(3), 172-177.
- Dunn, R. (1982). *Teaching students through their individual learning styles: A research report*. Reston, VA: National Association of Secondary School Principals.
- Gann, J. P. (1987). *Learning styles: Strategies for classroom teachers*. Annapolis, MD: Anne Arundel County Public Schools.
- Guralnik, F. (1984). *Webster's new world dictionary*. New York: Warner Communications.
- Hotchkiss, L. & Vetter, L. (1987). *Outcomes of career guidance and counseling*. Columbus: National Center for Research in Vocational Education, The Ohio State University.
- Johnson, C. D. (1982). *Individual guidance assessment*. Annapolis, MD: Anne Arundel County Public Schools.
- Johnson, C. D. & Johnson, S. K. (1982). Competency-based training of career development specialists or Let's get off the calf path. *Vocational Guidance Quarterly*, 30, 327-35.

- Johnson, C.D., Johnson, S.K. & Gerstein, M. (1987). *Guidance 2000 AD*. Annapolis, MD: Anne Arundel County Public Schools.
- Johnson, C.D. & Johnson, S.K. (1973). *Guidance advisory councils*. Mesa, AZ: Mesa Public Schools.
- Kiersey, D. & Bates, M. (1973). *Results system management*. Monograph no. 6. Fullerton, CA: California Personnel and Guidance Association.
- Kurpius, D.J. & Brubaker, J.C. (1976). *Psychoeducational consultation: Definitions-functions-preparations*. Bloomington: Indiana University.
- Morales, M. & Sheator, J. (1986). *Social work: A profession of many faces* (4th ed.). Newton, MA: Allyn and Bacon.
- Myers, I. & McCaulley, M. (1986). *A guide to the development and use of the Myers-Briggs type indicator*. Palo Alto, CA: Consulting Psychology Press.
- Myrick, R.D. (1987). *Developmental guidance and counseling: A practical approach*. Minneapolis: Educational Media Corporation, 336.
- National Committee on Excellence in Education (1983). *A nation at risk: The imperative for educational reform*. Washington, DC: U.S. Department of Education.
- Schmidt, J.I. & Medl, W.A. (1983). Six magic steps of consulting. *The School Counselor*, January, 212-216.
- Ulmansky, D.L. & Holloway, E.L. (1984). The counselor as consultant: From model to practice. *The School Counselor*, 31(4), 329-338.
- Wellman, F. (1964). *The national study of guidance taxonomy of objectives*. In Monograph no. 3. Fullerton, CA: California Personnel and Guidance Association.
- Whitfield, E. (1986). President's message. *NVGA Newsletter*.